DRAFT PERFORMANCE WORK STATEMENT (PWS)
Outpatient Site of Care per VHA Handbook 1006.02 "VHA Site Classifications and Definitions"

1. **GENERAL:**
   1.1. **SERVICES REQUIRED**: The Tennessee Valley Healthcare System (TVHS); requires the following services to be provided in a private hospital, office or clinic environment to veterans, primarily residing in the Cookeville and Roane County Tennessee areas:

[X]	Select the Site of Care with an [X]. Enter [NA] for "Not Applicable" for all other site classifications.
Community Based Outpatient Clinic (CBOC)	
[X]	Primary Care CBOC: offer both Primary Care and mental health care physically on-site (telehealth may be offered in addition but not as primary source) and may offer support services such as pharmacy, laboratory, and x-ray. Primary Care CBOCs are required to provide both primary care and mental health services. Sites that do not provide both primary care and mental health services are classified as Other Outpatient Services. Access to specialty care is not provided on site, but may be available through referral or telehealth. A Primary care CBOC often provides home-based primary care (HBPC) and home telehealth to the population it serves to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care. Primary care in VA includes both medical and mental health care services, as they are inseparable in providing personalized, proactive, patient-centered health care. **Primary Care Requirements.** A point of service is said to provide primary care services if the site registers more than 500 primary care encounters within the primary care stop class within a given fiscal year. **Mental Health Requirements.** A point of service is said to provide mental health services if the site registers more than 500 mental health encounters within a single mental health clinic stop class within a given fiscal year. Upon VA approval, Mental health services may be provided using telehealth, if the workload at the point of service would not otherwise justify the presence of mental health providers.
[N/A]	Multi-Specialty CBOC: offers both primary and mental health care and two or more specialty services physically on site. Access to additional specialty services may be offered by referral or telehealth. These clinics may offer support services, such as pharmacy, laboratory, and x-ray. The clinic may be operational from 1 to 7 days per week. These clinics are permitted to provide invasive procedures with local anesthesia or minimal sedation, but not with moderate sedation or general anesthesia (see VHA Directive 2006-023). **Requirements.** Multi-Specialty CBOCs are subject to the same requirements as Primary Care CBOCs, and are also required to provide multiple (two or more) specialty services. **Specialty Care Requirements.** A point of service is said to provide a specialty service if the site registers more than 500 encounters within a single specialty clinic stop class (e.g., cardiology, neurology, etc.) within a given fiscal year. A site must provide at least two specialties at this level to be classified as a multi-specialty clinic.
Health Care Center (HCC)	
[N/A]	HCC Ambulatory Surgery Clinic (ASC) must meet the requirements of the assigned surgical complexity level and provide all associated support infrastructure, such as pharmacy, laboratory, and x-ray, to perform these health care services safely and effectively. ASC programs are evaluated against clinical criteria established by VHA's National Surgery Office (see VHA Directive 2011-037).
[N/A]	HCC NOT designated as ASC but performing invasive procedures under moderate sedation (must meet criteria established by VHA Directive 2006-023 "Moderate Sedation by Non-Anesthesia Providers"
Other Outpatient Clinical Services Site of Care (Less than 500 encounters registered in primary care and mental health stop class within any given fiscal year or does not include MH Services)	
[N/A]	Clinical services are provided to remote areas through a Telehealth clinic or other arrangement. If any other services are provided in this venue (external to a VA clinic or facility), they must be associated with, attached to, and coordinated by a health care delivery site located in a clinic or facility.

1.1. **PLACE OF PERFORMANCE**: The requested services will be provided in the Cookeville, Tennessee and Roane County, Tennessee areas, which are located approximately one hour and fifteen minutes and 2 hours and ten minutes from both our VA Medical Center locations.

1.2. **AUTHORITY:** In accordance with Title 38 United States Code (USC) 8153 to be furnished by the contractor on behalf of the Tennessee Valley Healthcare System.

1.3. **POLICY AND REGULATIONS**: The Contractor is required to meet VHA performance and quality criteria and standards including, but not limited to, customer satisfaction, prevention index, chronic disease index and clinical guidelines. Performance and quality standards may change during the course of the contract. New or revised quality/performance criteria or standards will be provided to the Contractor before implementation date. Compliance with mandated performance is required as a condition of this contract. Contractor shall comply with all relevant VA policies and procedures, including those related to quality, patient safety and performance, including, but not limited to, the following:

1.3.1. Title 21 C.F.R 900.12(c) Mammography Quality Standards
http://www.gpo.gov/fdsys/pkg/CFR-2012-title21-vol8/pdf/CFR-2012-title21-vol8-sec900-12.pdf

1.3.2. Title 21 CFR "Food and Drugs" Section 1300-end. http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title21/21tab_02.tpl

1.3.3. 38 USC. Section 7332, regarding a timely special consent for any medical treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia, to a Veteran with health insurance. A special consent from the Veteran is needed to allow VA to release bills and medical records associated with the treatment.
http://www.gpo.gov/fdsys/granule/USCODE-2011-title38/USCODE-2011-title38-partV-chap73-subchapIII-sec7332/content-detail.html

1.3.4. 42 CFR Part 482 Conditions of Participation http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol5/pdf/CFR-2010-title42-vol5-part482.pdf

1.3.5. 42 CFR 493.15(b) Laboratories performing waived tests: http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol3/pdf/CFR-2003-title42-vol3-sec493-17.pdf

1.3.6. Clinical Laboratory Improvement Amendments (CLIA): http://cms.hhs.gov/Regulations-and-Guidance/Legislation/CLIA/index.html?redirect=/clia/appendc.asp

1.3.7. VHA Directive 2006-041, Veterans Health Care Service Standards: The care provided by the Contractor should be patient centered, continuous, accessible, coordinated, and consistent with VA standards, including the thirteen service standards detailed in VHA Directive 2006-041, "Veterans Health Care Service Standards," dated 6/27/06 (2006-041 expired on June 30, 2011 but will still be effective until a revision or rescission is published and/or subsequent revisions thereto.
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1443

1.3.8. VA Directive 1663: Health Care Resources Contracting - Buying
http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=347

1.3.9. VA Directive 6371, Destruction of Temporary Paper Records
http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=742&FType=2

1.3.10. VHA Record Control Schedule 10-1 http://www1.va.gov/vhapublications/rcs10/rcs10-1.pdf

1.3.11. "Patient Medical Records-VA" (24VA19). 24VA19
http://vaww.vhaco.va.gov/privacy/SystemofRecords.htm.

1.3.12. VHA Directive 2006-041 "Veterans' Health Care Service Standards" (expired but still in effect pending revision) https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1443

1.3.13. VHA Directive 2007-01 Coordinated Care Policy for Traveling Veterans.
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1562

1.3.14. VHA Directive 2007-033 "Telephone Service for Clinical Care,"
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1605

1.3.15. VHA Directive 2008-015 "Public Access to Automated External Defibrillators (AEDs): Deployment, Training, and Policies for use in VHA Facilities"
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1665

1.3.16. VHA Directive 2009-019, "Ordering and Reporting Test Results,"
www.**va**.gov/**vha**publications/ViewPublication.asp?pub_ID=1864

1.3.17. VHA Directive 2009-038 "VHA National Dual Care Policy"
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2058

1.3.18. VHA Directive 2010-020 "Anticoagulation Management"
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2234

1.3.19. VHA Directive 2010-027 "VHA Outpatient Scheduling Processes and Procedures"
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2252

1.3.20. VHA Directive 2010-033 "Military Sexual Trauma (MST) Programming,"
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2272

1.3.21. VHA Directive 2011-012 "Medication Reconciliation"
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2390

1.3.22. VHA Handbook 1003.4, "VHA Patient Advocacy Program,"
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1303.

1.3.23. VHA Handbook 1006.02 "VHA Site Classifications and Definitions"
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2970

1.3.24. VHA Handbook 1100.17: National Practitioner Data Bank Reports -
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2135

1.3.25. VHA Handbook 1100.18 Reporting And Responding To State Licensing Boards -
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1364

1.3.26. VHA Handbook 1100.19 Credentialing and Privileging -
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2818

1.3.27. VHA Handbook 1101.02 Primary Care Management Module.
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2017

1.3.28. VHA Handbook 1101.10 Patient Aligned Care Team (PACT)
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2977

1.3.29. VHA Handbook 1105.03 "Mammography Program Procedures and Standards"
http://www1.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=2411

1.3.30. VHA handbook 1106.1 "Pathology and Laboratory Medicine Service Procedures
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1779

1.3.31. Handbook 1120.2, "Health Promotion and Disease Prevention Core Program Requirements"
http://www1.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=1501.

1.3.32. VHA Handbook 1122.01, "VHA Handbook 1122.01, "Podiatric Medical and Surgical Services for Veterans Health Administration Medical Facilities"
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2122

1.3.33. VHA Directive ~~Handbook~~ 1330.1, "VHA Services for Women Veterans" dated 02/15/17 ~~7/16/04~~, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5332

1.3.34. Handbook 1160.01 "Uniform Mental Health Services"
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762

1.3.35. Privacy Act of 1974 (5 U.S.C. 552a) as amended
http://www.justice.gov/oip/foia_updates/Vol_XVII_4/page2.htm

1.3.36. VHA Handbook 5005, Part 2, Appendix G15, Licensed Pharmacist Qualification Standards.
http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=512&FType=2

1.3.37. VA Directive 0730
https://www.va.gov/vapubs/Search_action.cfm

1.3.38. VA Handbook 0730
https://www.va.gov/vapubs/Search_action.cfm

1.3.39. VA Directive 0730/4
https://www.va.gov/vapubs/Search_action.cfm

1.3.40. VHA Directive 1605.01, Privacy and Release of Information
VHA Directive 1605.01, Privacy and Release of Information

1.4. **DEFINITIONS/ACRONYMS:**

1.4.1. ABMS: American Board of Medical Specialties

1.4.2. ACLS: Advanced Cardiac Life Support

1.4.3. ACGME: Accreditation Council for Graduate Medical Education

1.4.4. ACPE: American Council on Pharmaceutical Education

1.4.5. ACO: Administrative Contracting Officer

1.4.6. ADE: adverse drug events
1.4.7. AED: Automatic External Defibrillator
1.4.8. AIS: Automated Information Security
1.4.9. ANA: American Nurses Association
1.4.10. AOA: American Osteopathic Association
1.4.11. ARRT: American Registry of Radiologic Technology
1.4.12. ASC: Ambulatory Surgery Clinic
1.4.13. Assigned:A veteran is "assigned" to an outpatient clinic via PCMM (i.e. CBOC) where the patient receives their primary care after the patient's eligibility is determined through registration and enrollment.
1.4.14. BAA : Business Associate Agreement
1.4.15. BI-RADS: Breast Imaging-Reporting and Data System; a quality assurance tool designed to standardize mammography reporting
1.4.16. BLS: Basic Life Support
1.4.17. BOS: Bureau of Osteopathic Specialists
1.4.18. CAHEA: Committee on Allied Health Education and Accreditation
1.4.19. CAP: College of American Pathologists
1.4.20. CARF: Commission on Accreditation of Rehabilitation Facilities
1.4.21. CBO: VA Central Billing Office.
1.4.22. CDC: Centers for Disease Control and Prevention
1.4.23. CEU: Certified Education Unit
1.4.24. CLIA: Clinical Laboratory Improvement Amendments
1.4.25. CME: Continuing Medical Education
1.4.26. CMS: Center for Medicare and Medicaid Services
1.4.27. CO: Contracting Officer
1.4.28. COPD: chronic obstructive pulmonary disease
1.4.29. COR: Contracting Officer's Representative
1.4.30. COS: Chief of Staff
1.4.31. CPA: collaborative practice agreement
1.4.32. CPS : Clinical Pharmacy Specialist
1.4.33. CPT: Current Procedural Terminology
1.4.34. CRNP: Certified Registered Nurse Practitioners
1.4.35. CSWE: The Council on Social Work Education The CSWE website is http://www.cswe.org/.
1.4.36. CPARS: Contractor Performance Assessment Reporting System
1.4.37. CPRS: Computerized Patient Recordkeeping System- electronic health record system used by the VA.
1.4.38. CVT: clinical video telehealth
1.4.39. DICOM: Digital Image and Communication in Medicine
1.4.40. DIGMA: Drop In Group Medical Appointment
1.4.41. DRG: Diagnostic Related Group
1.4.42. DSS: Decision Support System
1.4.43. ECC Extended Care Center
1.4.44. Enrollment**:** The process of establishing eligibility for VA's "Medical Benefits Package." Most Veterans are required to "enroll" into the VA Health Care System to be eligible for VA health care and to be assigned to a outpatient clinic like a CBOC; however some can still receive care without enrolling. Applicants are only required to "enroll" once for VA health care unless they are determined ineligible for care at time of application or they have disenrolled.
1.4.45. EPRP: External Peer Review Program
1.4.46. FDA: Food and Drug Administration
1.4.47. FSMB: Federation of State Medical Boards
1.4.48. HCC: Health Care Center A HCC is a VA-owned, VA-leased, contract, or shared clinic operated at least 5 days per week that provides primary care, mental health care, on site specialty services, and performs ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia.
1.4.49. HHS: Department of Health and Human Services
1.4.50. HCFA: HealthCare Financing Administration

1.4.51. HICPAC: Healthcare Infection Control Practices Advisory Committee- a federal advisory committee made up of 14 external infection control experts who provide advice and guidance to the CDC and the Secretary of HHS regarding the practice of health care infection control, strategies for surveillance and prevention and control of health care associated infections in United States health care facilities.

1.4.52. HT: Home Telehealth

1.4.53. ICAVL: Intersocietal Commission for the Accreditation of Vascular Laboratories

1.4.54. INR: International Normalized Ratio

1.4.55. ISO: Information Security Officer

1.4.56. LIP: licensed independent practitioner

1.4.57. MCCR: Medical Care Cost Recovery

1.4.58. Mental Health Services: per VHA Handbook 1160.01 is meant to include services for the evaluation, diagnosis, treatment, and rehabilitation of both substance use disorders and other mental disorders.

General mental health services include:

(a) Diagnostic and treatment planning evaluations for the full range of mental health problems;
(b) Treatment services using evidence-based pharmacotherapy, or primary evidence-based psychotherapy for patients with mental health conditions and substance use disorders;
(c) Patient education;
(d) Family education when it is associated with benefits to the veterans;
(e) Referrals as needed to inpatient and residential care programs; and
(f) Consultation about special emphasis problems including Post Traumatic Stress Disorder (PTSD) and Military Sexual Trauma (MST).

Specialty mental health services include:

(a) Consultation and treatment services for the full range of mental health conditions;
(b) Evidence-based psychotherapy;
(c) Mental Health Intensive Case Management (MHICM);
(d) Psychosocial Rehabilitation Services, including: PRRCs, family psycho-education, family education, skills training, peer support, and Compensated Work Therapy (CWT) and supported employment;
(e) PTSD teams or specialists;
(f) MST special clinics;
(g) Homeless programs; and
(h) Specialty substance abuse treatment services.

1.4.59. MQSA: Mammography Quality Standards Act

1.4.60. MSN: Master of Science in Nursing

1.4.61. NCCPA: National Commission on Certification of Physician Assistants

1.4.62. NLN: National League for Nursing

1.4.63. NSQIP/CICSP: National Surgical Quality Improvement Program/Continuing Improvement in Cardiac Surgical Program

1.4.64. OTC: Over the Counter

1.4.65. PA: Physician Assistant

1.4.66. PACS: Picture Archiving and Communications System

1.4.67. PACT: Patient Aligned Care Team Background & Introduction: VA has implemented a PCMH model at all VA Primary Care sites which is referred to as PACT. This initiative supports VHA's Universal Health Care Services Plan to redesign VHA healthcare delivery through increasing access, coordination, communication, and continuity of care. PACT provides accessible, coordinated, comprehensive, patient-centered care, in team based environment including the active involvement of other clinical and non-clinical staff. PACT allows patients to have a more active role in their health care and is associated with increased quality improvement, patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and readmissions.

1.4.68. Parent Facility: VAMC responsible for performance monitoring and payment for contracted Outpatient Site of Care services.

1.4.69. PCMH: patient-centered medical home

1.4.70. PCMM: Primary Care Management Module- a software program used to track Primary Care Clinic Veteran rosters.
1.4.71. PCP: Primary Care Provider
1.4.72. Phar.D.: Doctor of Pharmacy
1.4.73. POC: Point of Care Testing
1.4.74. PRIMARY CARE VISIT:an episode of care furnished in a clinic that provides integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. The VHA site classification defines primary care as those encounters that occur within the primary care class of encounters.
1.4.75. PWS: Performance Work Statement
1.4.76. QAPI: Quality Assessment and Performance Improvement
1.4.77. QASP: Quality Assurance Surveillance Plan
1.4.78. RME: reusable medical equipment
1.4.79. SOP (Clinical): Scope of Practice
1.4.80. SELF- REFERRAL: Referring patients to Contractor's facility for follow-up care. Self-referral for outpatient services at the Contractor's facility is prohibited.
1.4.81. SMA: Shared Medical Appointments
1.4.82. SPD: Sterile Processing Division
1.4.83. SPE: Senior Procurement Executive
1.4.84. SPECIALTY CARE VISIT:. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral." These services are generally divided into two sub-categories: medicine specialties and surgery specialties. The VHA site classification defines specialty care as those encounters that occur within the geriatric medicine; allergy; cardiology; dermatology; emergency; employee health; endocrinology; gastroenterology; general medicine; hematology or oncology; infectious disease; nephrology; neurology; outreach; pulmonary or respiratory disease; rheumatology; amputation follow-up; amputation; anesthesia; cardio-thoracic; ear, nose, and throat (ENT); eye; general surgery; gynecology (GYN); neurosurgery; orthopedics; plastic surgery; urology; or vascular clinic stops.
1.4.85. SUPPORT STAFF: staff present in the clinic area assisting providers in the actual delivery of primary care to patients. It consists of RNs, LPNs, Medical Assistants, Health Technicians, and Medical Clerks in the clinic.
1.4.86. TJC: The Joint Commission
1.4.87. TIU: Text Integration Utility
1.4.88. TCT: Telehealth Clinical Technicians
1.4.89. VA: Veterans Affairs
1.4.90. VAMC: Veterans Affairs Medical Center
1.4.91. Vesting: A patient is "vested" when they receive a qualifiying visit at their assigned point of care where they have been enrolled. To remain vested (and on active enrollment for billing purposes) a patient must have a qualifying visit every twelve (12) months. This applies for both Primary Care and Mental Health billing.
1.4.92. VetPro: a federal web-based credentialing program for healthcare providers.
1.4.93. VHA: Veterans Health Administration
1.4.94. VISTA: Veterans Health Information Systems and Technology Architecture

2. STAFFING AND QUALIFICATIONS:

2.1. **MINIMUM PACT STAFFING REQUIREMENTS:** Sufficient support staff to conduct daily business, including such functions as patient registration, financial assessments, and medical record documentation in VISTA. The Contractor shall provide personnel in numbers and qualifications capable of fulfilling the standards outlined in the resultant contract. The Contractor shall provide a sufficient number of primary care providers so that each primary care provider has a caseload ratio to meet VA standards. Current standards (is this a standard or planning factor since PCMM dictates panel sizes?) for caseload ratios are based on fulltime physician care for 1200 patients, and midlevel provider care for 900 patients. The staffing standard for support staff shall be in ratios to Primary Care Providers of at least three support staff for each full time equivalent Primary Care Provider. Clinical Pharmacy Services: The CPS shall be provided the same support staffing given to other providers on the team when they are working in the capacity of a mid-level provider. The support staffing mix standard includes a registered nurse care manager for every 1200 patients served by the Outpatient Site of Care. Anticoagulation clinic management and Telephone Care for the primary care patients are also considered support staff, even if located in a separate area. Staff time dedicated to Business Office functions (means testing, registrations or billing), phlebotomy, file room activities, or supporting non-primary care clinics (e.g., podiatry, social work, and dietary) are not considered support staff for the purposes of this definition. These numbers may be adjusted, upon approval by the Government, based on the availability of exam rooms and support staff (refer to VHA Handbook 1101.02) . **If the number of patients reaches the maximum panel size per PCMM standards, the Contractor shall communicate to the VA the Contractor's future staffing plan to ensure VA contract staffing ratio standards in accordance with PCMM are maintained**. Request a "trigger point/level" be established for when a contractor will provide future staffing plan (e.g. 95%). Public Law 114 modifies the VA Choice Program eligibility requirements; therefore requiring a 0.9 FTEE primary care physician(s) providing at least 36 clinical care hours, or all Veterans in that CBOC area are eligible for the VA Choice Program.

2.1.1. STAFFING GRID:

PHYSICIAN DIRECTOR CHIEF MEDICAL OFFICER [X] Mandatory for all sites
FTE Ratio Standard: At least 0.05 FTE per 1200 patients Does the Physicain Director have to be on site or how much time must be on site? **Responsible Party:** Shall be provided by Contractor **Qualifications:** Contractor's Physicians (including subcontractors) providing physician director services under the resultant contract shall demonstrate evidence of education, training, and experience in Internal Medicine or Family Practice. Contactor's Physicians performing under this contract shall be board certified (or board eligible) (*delete board eligible if not acceptable for the Physician Director position)*by the ABMS in Internal Medicine and/or Family Practice or the BOS in Internal Medicine and/or Family Practice. 5 years of primary care experience without board cert or eligibility; 2 years with. Physicians shall be licensed in the state where the Outpatient Site of Care (i.e. CBOC) is located; If proposed staff do not meet VA credentialing requirements, the Contractor shall propose substitute acceptable personnel within five (5) calendar days **Position Responsibilities:** Serves as medical director to oversee and be responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site.
PRIMARY CARE STAFFING: Total Estimated Patients enrolled/assigned to site: **5100 @ Cookeville / 1700 @ Roane County** [X] Mandatory for all sites **Responsible Party:** All Primary Care Staffing shall be provided by Contractor
Primary Care Provider (PCP) FTE Ratio Standard: Physician provider FTE ratio: At least 1 FTE per 1200 patients Mid-level provider FTE ratio standard: At least 1 FTE per 900 patients. Contractor shall propose quantity of FTE to meet Standard FTE ratio to panel size. Contractor to propose the type and quantity of PCP from the options below.

Physician	**Qualifications:** Physicians providing physician director services under the resultant contract shall demonstrate evidence of education, training, and experience in Internal Medicine or Family Practice. Physicians performing under this contract shall be board certified by the ABMS in Internal Medicine and/or Family Practice or the BOS in Internal Medicine and/or Family Practice. Authorization for prescriptive authority is required. Physicians shall be licensed in the state where the Outpatient Site of Care (i.e. CBOC) is located; If proposed staff do not meet VA credentialing requirements, the Contractor shall propose substitute acceptable personnel within five (5) calendar days **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care.
Certified Registered Nurse Practitioner (CRNP)	**Qualifications:** CRNP's (including subcontractors) must have a MSN from a NLN accredited nursing program and have ANA Certification as a Nurse Practitioner in either Adult Health or Family Practice. Authorization for prescriptive authority is required. Three years of clinical nursing experience is required. A minimum of ~~one (1) year~~ two (2) years clinical experience as a CRNP is required (three (3) years preferred). Experience in outpatient care in a Family Medicine or Internal Medicine environment is ~~preferred~~ required. CRNP shall have current, full, active, and unrestricted license and registration as a graduate professional nurse in the state of the Outpatient Site of Care (i.e. CBOC); **Reference VA Handbook 5005, Appendix G6** **http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=464&FType=2** **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care.
Physician Assistant (PA)	**Qualifications:** PA's (including subcontractors) must meet one of the three following educational criteria: a) A bachelor's degree from a PA training program which is certified by the CAHEA; or b) Graduation from a PA training program of at least twelve (12) months duration, which is certified by the CAHEA and a bachelor's degree in a health care occupation or health related science; or c) graduation from a PA training program of at least twelve (12) months duration which is certified by the CAHEA and a period of progressively responsible health care experience such as independent duty medical corpsman, licensed practical nurse, registered nurse, medical technologist, or medical technician. The duration of approved academic training and health care experience must total at least five (5) years. A minimum of two (2) years clinical experience as a PA is required (three (3) years preferred). Experience in outpatient care in a Family Medicine or Internal Medicine environment is required. Authorization for prescriptive authority is required. PAs must be certified by the NCCPA. PA shall have current, full, active, and unrestricted license and registration in the state of the Outpatient Site of Care (i.e. CBOC); **VA HANDBOOK 5005/78 PART II APPENDIX G8 PHYSICIAN ASSISTANT QUALIFICATION STANDARD** **http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=763&FType=2** **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care.

PRIMARY CARE STAFFING – REGISTERED NURSE CARE MANAGER [X] Mandatory for all sites	
Registered Nurse (RN) Care Manager	**FTE Ratio Standard:** At least 1 FTE 1200 patients per PACT Provider not # of patients Reference VA Handbook 5005, Appendix G6 http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=464&FType=2 **Qualifications:** Graduate of a school of professional nursing approved by the appropriate State-accrediting agency **and** accredited by one of the following accrediting bodies at the time the program was completed by the applicant: The accreditation Commission for Education in Nursing (ACEN) or The commission on Collegiate Nursing Education (CCNE). Current, full, active, and unrestricted registration as a graduate professional nurse in the state of the Outpatient Site of Care (i.e. CBOC); Authorization for prescriptive authority is required. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site. The RN collaborates for the improvement of patient care outcomes in the Patient Aligned Care Team. Promotes systems to improve access and continuity of care, uses advanced clinical knowledge and critical thinking skills to mentor staff in planning, implementing and evaluating interventions that improve patient outcomes, designs and provides age and population specific health promotion and risk reduction strategies, translates evidence-based research into practice to ensure that patients benefit from the latest innovations in nursing science, manages patients in transition between levels of care,serves as an expert resource to implement

	and teach skills, including motivational interviewing to promote patient self-management toward patient-driven holistic care plan for life.
PRIMARY CARE STAFFING – CLINICAL ASSOCIATE [X] Mandatory for all sites	
CLINICAL ASSOCIATE FTE Ratio standard: At least 1 FTE 1200 patients per PACT Provider not # of patients Contractor to propose the type and quantity of Clinical Associate from the options below.	
Licensed Practical Nurse (LPN)	**Qualifications:** VA HANDBOOK 5005/3 PART II APPENDIX G13 LICENSED PRACTICAL OR VOCATIONAL NURSE QUALIFICATION STANDARD http://vaww.va.gov/OHRM/Directives-Handbooks/Documents/5005.pdf Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC)**Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site. Duties include but are not limited to the ability to perform a variety of specialized clinical support skills, ability to perform basic patient care service, have knowledge of medical terminology, demonstrate skills in interpersonal communication, demonstrate knowledge of aseptic technique and infection control and knowledge of patient confidentiality, policies and procedures. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas.
Licensed Vocational Nurse (LVN)	**Qualifications:** VA HANDBOOK 5005/3 PART II APPENDIX G13 LICENSED PRACTICAL OR VOCATIONAL NURSE QUALIFICATION STANDARD http://vaww.va.gov/OHRM/Directives-Handbooks/Documents/5005.pdf Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site. Duties include but are not limited to the ability to perform a variety of specialized clinical support skills, ability to perform basic patient care service, have knowledge of medical terminology, demonstrate skills in interpersonal communication, demonstrate knowledge of aseptic technique and infection control and knowledge of patient confidentiality, policies and procedures. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas. Shall receive training as a back-up for Telehealth Services (e.g. S&F, CVT).
Medical Assistant (MA)	**Qualifications**: Completion of an approved medical assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES), or by any accrediting agency recognized by the United States Department of Education or a current and active Certified Medical Assistant (CMA) or Registered Medical Assistant (RMA) from The American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT). Other credentials such as completion of a medical services training program of the Armed Forces of the United States may be accepted based on Chief of Staff determination. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site. Duties include but are not limited to the ability to perform a variety of specialized clinical support skills, ability to perform basic patient care service, have knowledge of medical terminology, demonstrate skills in interpersonal communication, demonstrate knowledge of aseptic technique and infection control and knowledge of patient confidentiality, policies and procedures. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas
Health Care Technician (HCT) (as part of PACT teamlet	**Qualifications:** Completion of an approved medical assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or the Accrediting Bureau of Health Education Schools (ABHES), or by any accrediting agency recognized by the United States Department of Education or a current and active Certified Medical Assistant (CMA) or Registered Medical Assistant (RMA) from The American Association of Medical Assistants (AAMA) or the American Medical Technologists (AMT). Other credentials such as completion of a medical services training program of the Armed Forces of the United States may be accepted based on Chief of Staff determination. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care at the site. Shall assist all health care providers in performing patient care services and duties pertaining to the effective and efficient delivery of patient centered care in all clinical areas.
PRIMARY CARE STAFFING – CLERICAL ASSOCIATE [X] Mandatory for all sites	

CLERICAL ASSOCIATE **FTE Ratio Standard**: At least 1 FTE per 1200 patients Personnel provided by the contractor (including subcontractors) shall provide the education and credentials of each clinical employee by name (C.V. and/or resume acceptable).	
Clerical Associate	**Qualifications:** Required education and experience demonstrating skills and abilities to perform duties ensuring smooth site operations. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care.
EXPANDED PACT STAFFING- CLINICAL PHARMACY SERVICES	
Clinical Pharmacy Specialist (CPS) -PACT	**FTE Ratio Standard**: 0.3 FTE patient panel 1200 per PACT Provider not # of patients **Qualifications:** Required education and experience demonstrating skills and abilities to perform duties ensuring smooth site operations. CPS who is a licensed pharmacist who is a graduate of an Accreditation Council for Pharmacy Education (ACPE) accredited College or School of Pharmacy with a baccalaureate degree in pharmacy (BS Pharmacy) and/or a Doctor of Pharmacy (Pharm.D.) degree and has at least 1 year of pharmacy equivalent experience at the next lower level at time of employment. In addition to the requirements listed above, the CPS must meet licensed qualification standards to include a graduate of a degree program in pharmacy from an approved college or university and have post-graduate experience performing chronic disease state and medication management services (e.g., post-graduate residency, direct patient care under collaborative practice agreement or similar equivalent experience). The CPS has duties and responsibilities as defined in VHA Handbook 5005, Part 2, Appendix G15, Licensed Pharmacist Qualification Standards. Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=512&FType=2 . Authorization for a VA scope of practice is required, in accordance with VHA Directives 2008-043 and 2009-014 or subsequent policy release, and must adhere to pharmacy practice acts within that state. If proposed staff do not meet VA credentialing requirements, the Contractor shall propose substitute acceptable personnel within five (5) calendar days. **Position Responsibilities:** Responsible for the provision of comprehensive medication management services (generally 1 CPS per 3600 primary care patients). The staffing ratio may be adjusted locally or according to national guidance from relevant program offices when taking into account the services provided by the CPS, degree of ancillary and clerical support, and the size and complexity of the panels being managed. Responsible for the provision of covered services to enrolled and unassigned patients presenting for care. Clinical Pharmacy Specialists shall be scheduled to sufficiently provide the needs of enrolled patients functioning in the capacity of a mid-level provider (under SOP or collaborative practice agreement) as their primary duty is to assist providers with comprehensive medication management (anticoagulation and chronic primary care disease management).
Clinical Pharmacy Specialist (CPS) Anti-coagulation	**FTE Ratio Standard**: 0.2 FTE patient panel 1200 per PACT Provider not # of patients **Qualifications:** Required education and experience demonstrating skills and abilities to perform duties ensuring smooth site operations. CPS who is a licensed pharmacist who is a graduate of an Accreditation Council for Pharmacy Education (ACPE) accredited College or School of Pharmacy with a baccalaureate degree in pharmacy (BS Pharmacy) and/or a Doctor of Pharmacy (Pharm.D.) degree and has at least 1 year of pharmacy equivalent experience at the next lower level at the time of employment. In addition to the requirements listed above, the CPS. Pharmacists must meet licensed qualification standards to include a graduate of a degree program in pharmacy from an approved college or university and have post-graduate experience performing chronic disease state and medication management services (e.g., post-graduate residency, direct patient care under collaborative practice agreement or similar equivalent experience). The degree program must have been approved by the ACPE. Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC).The CPS has duties and responsibilities as defined in VHA Handbook 5005, Part 2, Appendix G15, Licensed Pharmacist Qualification Standards http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=512&FType=2 . Authorization for a VA scope of practice is required, in accordance with VHA Directives 2008-043 and 2009-014 or subsequent policy release, and must adhere to pharmacy practice acts within that state. If proposed staff do not meet VA credentialing requirements, the Contractor shall propose substitute acceptable personnel within five (5) calendar days . **Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care. Clinical Pharmacy Specialists shall be scheduled to sufficiently provide the needs of enrolled patients functioning in the capacity of a mid-level provider (under SOP or collaborative practice

	agreement) as their primary duty is to assist providers with comprehensive medication management (anticoagulation and chronic primary care disease management). PACT-CPS Anticoagulation at least 1.0 clinical pharmacy specialist full-time equivalent (FTE) for every five PACT patient panels, this is an estimate based of the number of warfarin patients expected in a typical PACT panel and may not be representative of the number of patients who require anticoagulation management services on any given team. In evaluating facilities with strong practices in VHA, evidence suggests that anticoagulation providers achieve optimal clinical outcomes when patient ratios are maintained at approximately 350 to 400 patients per anticoagulation provider, with strong assumption of adequate support staff (e.g., 1 pharmacy technician FTE per 2 clinical pharmacist anticoagulation provider FTE).
EXPANDED PACT STAFFING CONTINUED	
Licensed Clinical Social Worker	**FTE Ratio Standard**: 0.5 FTE patient panel 1200 per PACT Provider not # of patients **Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) Social Workers providing services under this contract must have a Master's degree in Social Work (MSW) from a school accredited by Council on Social Work Education (CSWE). **VA HANDBOOK 5005/23 PART II APPENDIX G39 SOCIAL WORKER QUALIFCATION STANDARD GS-185** *http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=481&FType=2* **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care.
Registered Dietitian Nutritionist	**FTE Ratio Standard**: 0.2 FTE patient panel 1200 (per PACT Provider not # of patients) Staffing ratio may be adjusted upward locally to provide appropriate medical nutrition therapy or education. Two new contracts awarded, state "*TVHS will provide access to Dietician services via Telehealth, if the Contractor does not provide*". This seems to give the Contractor an option to staff or not, then it becomes TVHS responsibility to provide service. Recommend language to the effect, "*If nutrition services at contracted site are not at an adequate level to retain Registered Dietician staff, then Contractor can initiate negotiations with Contracting Officer for TVHS coverage via Telehealth*." **Qualifications:** Meet state qualification requirements in the state of the Outpatient Site of Care (i.e. CBOC). Bachelor's degree from a U.S. regionally accredited college or university and completed a didactic program in dietetics accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND), formerly known as the Commission on Accreditation for Dietetic Education (CADE). Completed an ACEND accredited or approved supervised practice program. Supervised practice programs are post-baccalaureate degree programs that provide supervised practice experiences which meet the eligibility requirements and accreditation standards of ACEND, formally known as CADE. Completion of a coordinated program in dietetics fulfills the requirements of a supervised practice program. Time spent in a dietetic internship or supervised practice program does not qualify as creditable experience. Dietitian must be registered with the Commission on Dietetic Registration (CDR) the credentialing branch of the Academy of Nutrition and Dietetics formerly known as the American Dietetic Association (ADA). Advanced Level Practice Dietitians must possess a minimum of one advanced practice credential relevant to the area of practice, (e.g. Certified Nutrition Support Clinician (CNSC), Board Certified Specialist in Renal Nutrition (CSR), Board Certified Specialist in Gerontological Nutrition (CSG), Certified Diabetes Educator (CDE), or Board Certified Specialist in Oncology Nutrition (CSO)). **VA HANDBOOK 5005/80 PART II APPENDIX G20 DIETITIAN QUALIFICATION STANDARD GS-630** http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=764&FType=2 **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care. Registered Dietitian Nutritionist scheduled to sufficiently provide for the needs of enrolled patients and to meet all VA scheduling requirements / mandates.

EXPANDED PACT STAFFING- PRIMARY CARE MENTAL HEALTH INTEGRATION (PCMHI)	
Primary MH Provider staffing level for PCMHI: FTE Ratio Standard - .5 FTE per 1000 patients. A mix of the following provider types may be selected to meet FTE staffing level required. If a non-perscribing provider is selected, outpatient site must have a collaborating provider onsite to prescribe in consult with the mental health integration staff member assigned. Staffing ratio outlined is "minimum" and may be adjusted locally by the VA to provide appropriate Mental Health Care.	
Psychiatrist	**Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC). **Position Responsibilities:** Responsible for collaboration with PACT team for the provision of Mental Health services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract. Position is co-located on site with PACT team and services shall be delivered face-to-face.
Psychologist	**Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC). **Position Responsibilities:** Responsible for collaboration with PACT team for the provision of Mental Health services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract. Position is co-located on site with PACT team and services shall be delivered face-to-face.
Advanced Practice Nurse	**Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC). **Position Responsibilities:** Responsible for collaboration with PACT team for the provision of Mental Health services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract. Position is co-located on site with PACT team and services shall be delivered face-to-face. Any MH training / experience requirements? Similar to APRN on page 19.
Licensed Professional Mental Health Counselor (LPMHC)	**Qualifications:** Hold a master's degree in mental health counseling, or a related field, from a program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP). Examples of related mental health counseling fields include, but are not limited to, Addiction Counseling; Community Counseling; Gerontology Counseling; Marital, Couple, and Family Counseling; and Marriage and Family Therapy. A doctoral degree in mental health counseling may not be substituted for the master's degree in mental health counseling. Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) to independently practice mental health counseling, which includes diagnosis and treatment. **Position Responsibilities:** Responsible for collaboration with PACT team for the provision of Mental Health services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract. Position is co-located on site with PACT team

	and services shall be delivered face-to-face.
Additional MH Service staffing level required for PCMHI: **FTE RatioStandard: .17 FTE per 1000 patients.** Staffing ratio outlined is "minimum" and may be adjusted locally by the VA to provide appropriate Mental Health Care.	
Licensed Clinical Social Worker	**Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) Social Workers providing services under this contract must have a Master's degree in Social Work (MSW) from a school accredited by Council on Social Work Education (CSWE) . **VA HANDBOOK 5005/23 PART II APPENDIX G39 SOCIAL WORKER QUALIFICATION STANDARD GS-185** *http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=481&FType=2* **Position Responsibilities:** Responsible for disease care management the provision of covered services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract. Position is co-located on site with PACT team and services shall be delivered face-to-face and by telephone from the outpatient site location.
Registered Nurse (RN)	Reference VA Handbook 5005, Appendix G6 http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=464&FType=2 **Qualifications:** Graduate of a school of professional nursing approved by the appropriate State-accrediting agency **and** accredited by one of the following accrediting bodies at the time the program was completed by the applicant: The accreditation Commission for Education in Nursing (ACEN) or The commission on Collegiate Nursing Education (CCNE). Current, full, active, and unrestricted registration as a graduate professional nurse in the state of the Outpatient Site of Care (i.e. CBOC); Authorization for prescriptive authority is required. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for mental health care at the site. The RN collaborates for the improvement of patient care outcomes in the Patient Aligned Care Team.Promotes systems to improve access and continuity of care, uses advanced clinical knowledge and critical thinking skills to mentor staff in planning, implementing and evaluating interventions that improve patient outcomes, designs and provides age and population specific health promotion and risk reduction strategies, translates evidence-based research into practice to ensure that patients benefit from the latest innovations in nursing science, manages patients in transition between levels of care, serves as an expert resource to implement and teach skills, including motivational interviewing to promote patient self-management toward patient-driven holistic care plan for life.
Licensed Professional Mental Health Counselor (LPMHC)	**Qualifications:** Hold a master's degree in mental health counseling, or a related field, from a program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP). Examples of related mental health counseling fields include, but are not limited to, Addiction Counseling; Community Counseling; Gerontology Counseling; Marital, Couple, and Family Counseling; and Marriage and Family Therapy. A doctoral degree in mental health counseling may not be substituted for the master's degree in mental health counseling. Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) to independently practice mental health counseling, which includes diagnosis and treatment. **Position Responsibilities:** Responsible for collaboration with PACT team for the provision of Mental Health services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract. Position is co-located on site with PACT team and services shall be delivered face-to-face.

Suicide Prevention Coordinator (SPC)	*In sites treating 10,000 patients the ratio standard is to incluide a dedicated specialist. In smaller sites serving less than 10,000, the standard is that this may be a collateral assignment.* **Licensed Clinical Social Worker** **Psychologist**
Homeless Outreach Specialist	Outreach specialist, usually a licensed clinical social worker, licensed clinical "psychotherapist", to provide services to homeless veterans. *In sites treating 10,000 patients the ratio standard is to incluide a dedicated specialist. In smaller sites serving less than 10,000, the standard is that this may be a collateral assignment.*

The following MH chart represents "Additional" MH Services (not Integrated MH Services). If site does not require additional specialty Mental Health Services, please highlight and strike out and request that the section be deleted for the requirement.

GENERAL SPECIALTY MENTAL HEALTH STAFFING	
~~**Psychiatrist**~~ **Delete**	**FTE Ratio Standard**: 1.22 FTE per 1000 patients requiring mental health services. Staffing ratio may be adjusted upward locally to provide appropriate Mental Health Care **Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC). Board certified physician in psychiatry **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract.
MENTAL HEALTH COLLABORATIVE TEAM STAFFING VA Ratio standards 4 FTE to meet the psychotherapy, case management and additional prescriptive needs of the patient population.	
Primary MH Provider staffing level for PCMHI: FTE Ratio standard- 4 FTE per 1000 patients. A mix of the following provider types may be selected to meet FTE staffing level required. Staffing ratio outlined is "minimum" and may be adjusted locally by the VA to provide appropriate Mental Health Care.	
~~**Psychologist**~~ **Delete**	**Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) and a doctoral degree in psychology from a graduate program in psychology accredited by the American Psychological Association (APA) and successfully completed a professional psychology internship training program that has been accredited by APA. **VA HANDBOOK 5005/15 PART II APPENDIX G18 PSYCHOLOGIST QUALIFICATION STANDARD** **GS-180 http://vaww.va.gov/OHRM/Directives-Handbooks/Documents/5005.pdf** **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract.
~~**Advanced practice registered nurse**~~ **Delete**	http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=464&FType=2 Reference VA Handbook 5005, Appendix G6 **Qualifications:** Graduate of a school of professional nursing approved by the appropriate State-accrediting agency **and** accredited by one of the following accrediting bodies at the time the program was completed by the applicant: The accreditation Commission for Education in Nursing (ACEN) or The commission on Collegiate Nursing Education (CCNE). Current, full, active, and unrestricted registration as a graduate professional nurse in the state of the Outpatient Site of Care (i.e. CBOC); Authorization for prescriptive authority is required. Documentation of mental health licensure or prior experience in mental health settings required. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care according to VHA Handbook

	1160.01 and the requirements of this contract.
~~**Physician's Assistant**~~ **Delete**	**Qualifications:** Contractor's PA's (including subcontractors) must meet one of the three following educational criteria: a) A bachelor's degree from a PA training program which is certified by the CAHEA; or b) Graduation from a PA training program of at least twelve (12) months duration, which is certified by the CAHEA and a bachelor's degree in a health care occupation or health related science; or c) graduation from a PA training program of at least twelve (12) months duration which is certified by the CAHEA and a period of progressively responsible health care experience such as independent duty medical corpsman, licensed practical nurse, registered nurse, medical technologist, or medical technician. The duration of approved academic training and health care experience must total at least five (5) years. Authorization for prescriptive authority is required. PAs must be certified by the NCCPA. . PA shall have current, full, active, and unrestricted license and registration in the state of the Outpatient Site of Care (i.e. CBOC); **VA HANDBOOK 5005/78 PART II APPENDIX G8 PHYSICIAN ASSISTANT QUALIFICATION STANDARD http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=763&FType=2** Documentation of mental health licensure or prior experience in mental health settings required. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract.
~~**Licensed Clinical Social Worker**~~ **Delete**	**Qualifications:** Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) Social Workers providing services under this contract must have a Master's degree in Social Work (MSW) from a school accredited by Council on Social Work Education (CSWE). **VA HANDBOOK 5005/23 PART II APPENDIX G39 SOCIAL WORKER QUALIFCATION STANDARD GS-185** *http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=481&FType=2* **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract.
~~**Licensed Professional Mental Health Counselor (LPMHC)**~~ **Delete**	**Qualifications:** Hold a master's degree in mental health counseling, or a related field, from a program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP). Examples of related mental health counseling fields include, but are not limited to, Addiction Counseling; Community Counseling; Gerontology Counseling; Marital, Couple, and Family Counseling; and Marriage and Family Therapy. A doctoral degree in mental health counseling may not be substituted for the master's degree in mental health counseling. Current, full, active, and unrestricted license in the state of the Outpatient Site of Care (i.e. CBOC) to independently practice mental health counseling, which includes diagnosis and treatment. **Position Responsibilities:** Responsible for collaboration with PACT team for the provision of Mental Health services to enrolled and unassigned patients presenting for care according to VHA Handbook 1160.01 and the requirements of this contract. Position is co-located on site with PACT team and services shall be delivered face-to-face.

SPECIALTY SERVICES	
Podiatrist	**FTE Ratio Standard:** 1.0 FTE per patient panel 950 single room available for services or 1 FTE per patient panel 1300 with two rooms and clinical support (such as a nail technician) Staffing ratio may be adjusted upward locally to provide VA standard patient care average of 14 – 16 patients/8-hour period being seen. **Qualifications:** Degree of doctor of podiatric medicine, or its equivalent, from a school of podiatric medicine approved by the Secretary of Veterans Affairs. Approved schools are United States schools of podiatric medicine approved by the Council on Podiatry Education of the American Podiatry Association in the year in which the degree was granted. VHA Handbook 5005 Part II Appendix G4, p345 http://vaww.va.gov/OHRM/Directives-Handbooks/Documents/5005.pdf . Podiatrist Qualification Standards Intermediate Grade with experience necessary to run a clinical practice in a remote area. (1) Four years of podiatric practice or its equivalent. One year of the required experience must have been in a multidisciplinary clinical setting. Two years of approved residency training or its creditable equivalent acceptable to the Council on Podiatry Education of the American Podiatry Association and, as applicable, the appropriate specialty board is acceptable in lieu of 4 years of practice, including the above 1-year requirement. (2) The podiatrist at this level possesses stature that would warrant appointment at the clinical instructor or higher level at a school or college of podiatry or other appropriate affiliated school or college. (3) Has achieved a high level of professional attainment as illustrated by one or more of the following typical examples (more examples found in qualifications handbook link). (a) Is a recognized expert in dealing with a variety of unusually difficult cases which are referred by other facilities for resolution and recommended courses of action to provide for maximum rehabilitation. Typically, in this capacity serves as a consultant to podiatrists or other professionals in other health care facilities. (b) Has assumed responsibility for a comprehensive podiatry program at a facility for the care of diabetic, peripheral vascular disease and other systemic conditions involving the foot, and a program for the care of the geriatric patient. Typically, a high degree of competence and skill in responding to the needs of this patient category is demonstrated in the program development and innovative methods and techniques employed. Training in podiatry and medical or other appropriate professional areas and/or research activities of considerable scope commonly from a part of the program. Licensed in state of CBOC site. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care.
Diagnostic or Therapeutic Radiologic Technologist	Radiology staffing shall be according to the machine types and demands of the facility for each Radiologic procedure/ modality, i.e. CT, MRI, US, MAMMOGRAPHY, X-ray, etc. Radiologist staffing is based upon the number of exams and type performed in the typical 8 hour day. [ ] CT Machine staffing standard: Requires two (2) Technologists per 8 hour shift [ ] MRI Machine staffing standard: Requires two (2) Technologists per 8 hour shift [ ] Ultrasound Machine staffing standard requires one (1) Technologist per 8 hour shift [ ] X-Ray Machine staffing standard: Requires one (1) Technologist per machine per 8 hour shift. **Qualifications:** Must be certified in general radiologic technology by the ARRT and possess an active, current certification. Must meet radiological technologist requirements of the state in which the services are provided. **VA HANDBOOK 5005/77 part 2 Appendix G25 THERAPEUTIC RADIOLOGIC TECHNOLOGIST QUALIFICATION STANDARD** http://www.va.gov/vapubs/viewPublication.asp?Pub_ID=754&FType=2 **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care.

SPECIALTY SERVICES	
Tele-Retinal Healthcare Technician	**FTE Ratio standard 2.0 per estimated 1200 Panel size 1 primary and 1 back up** **Qualifications:** All staff employed providing telehealth related services into the clinic shall be appropriately credentialed and; where necessary, privileged. All contractor staff who support telehealth services must be working within permitted licensure and scope of practice. Where non-licensed staff is supporting telehealth services provided through the contractor they must do so under the appropriate clinical supervision.Competency - Teleretinal Imagers shall be expected to provide clinical care in compliance with established clinical protocol. Additional guidelines governing operations will be utilized and provided to Contractor by VA. The Teleretinal Imager shall be expected to successfully complete training programs required for certification as a Teleretinal Imager including VA required training and any VA training mandated for Teleretinal Imagers. Teleretinal Imagers shall be responsible for maintaining imager certification. Teleretinal Imagers shall be expected to demonstrate competency on the function and use of the digital retinal imaging system. VA will provide training to Teleretinal Imager and document competency. **Position Responsibilities:** Responsible for the provision of covered services to enrolled and unassigned patients presenting for care. The Contractor's teleretinal service shall include but are not limited to: coordinating teleretinal clinic set up, scheduling, coordination of consult loading into local CPRS account, consult management, provision of data on request, attendance on VA or Network Teleretinal Imaging Team calls, maintaining records required for quality control processes, and participating in performance improvement activities. The Contractor TCT shall be responsible for transmitting teleretinal images and all other supporting data to the assigned VA reading center within time lines established by policy. The Contractor shall notify patient of results within 14 days of procedure and is responsible for scheduling follow up evaluations based on clinical protocol. The Contractor shall be responsible for satisfying the clinical reminder for eye care. Patient Education – The Contractor's TCT shall provide basic education to patients including but not limited to: review of acquired images for anatomic and general findings, discussion with veteran regarding the association between glucose control and ocular health, review of the importance of receiving routine eye evaluations, review of photos, and provision of approved handouts. **Why is this designated as a position, this is usually a dual role for a TCT/Imager**
Tele Dermatology Health Care Technician	**FTE Ratio Standard #.# per estimated 1200 Panel size 1 primary** **Qualifications:** All staff employed providing telehealth related services into the clinic shall be appropriately credentialed and; where necessary, privileged. All contractor staff who support telehealth services must be working within permitted licensure and scope of practice. Where non-licensed staff is supporting telehealth services provided through the contractor they must do so under the appropriate clinical supervision. **Position Responsibilities:** TCT's will serve in a generalist role to support and manage tele-health clinical encounters from a patient and provider location as the Tele-presenter and imager for Tele-health store and forward applications. This position serves as the clinic manager for real time Tele-health events, including patient education activations, provision of equipment for the Home Tele-health program, technical and scheduling activities, training, developing and monitoring improvement process for all Tele-health activities as well as other program support duties as assigned. TCTs will perform patient screening and determine the cognitive, physical, emotional and chronological development of adult and geriatric patients effecting appropriate inter/intra facility and outpatient transportation. Ensure proper operation of equipment and products by performing routine maintenance and maintaining proper records for quality reports and workload reporting. **Why is this designated as a position, this is usually a dual role for a TCT/Imager, this staff takes direction and guidance from the FTC and Administraively under the NM at the site**

SPECIALTY SERVICES CONTINUED	
Tele-Psychiatry Healthcare Technician	**Qualifications:** All staff employed providing telehealth related services into the clinic shall be appropriately credentialed and; where necessary, privileged. All contractor staff who support telehealth services must be working within permitted licensure and scope of practice. Where non-licensed staff is supporting telehealth services provided through the contractor they must do so under the appropriate clinical supervision. **Position Responsibilities:** TCT's will serve in a generalist role to support and manage tele-health clinical encounters from a patient and provider location as the Tele-presenter and imager for Tele-health store and forward applications. This position serves as the clinic manager for real time Tele-health events, including patient education activations, provision of equipment for the Home Tele-health program, technical and scheduling activities, training, developing and monitoring improvement process for all Tele-health activities as well as other program support duties as assigned. TCTs will perform patient screening and determine the cognitive, physical, emotional and chronological development of adult and geriatric patients effecting appropriate inter/intra facility and outpatient transportation. Ensure proper operation of equipment and products by performing routine maintenance and maintaining proper records for quality reports and workload reporting.
Tele-Pharmacy Healthcare Technician	**FTE Ratio Standard #.# per estimated 1200 Panel size 1 primary** **Qualifications:** All staff employed providing telehealth related services into the clinic shall be appropriately credentialed and; where necessary, privileged. All contractor staff who support telehealth services must be working within permitted licensure, functional statement and scope of practice, as appropriate. Where non-licensed staff is supporting telehealth services provided through the contractor they must do so under the appropriate clinical supervision. **Position Responsibilities:** TCT's will serve in a generalist role to support and manage tele-health clinical encounters from a patient and provider location as the Tele-presenter and imager for Tele-health store and forward applications. This position serves as the clinic manager for real time Tele-health events, including patient education activations, provision of equipment for the Home Tele-health program, technical and scheduling activities, training, developing and monitoring improvement process for all Tele-health activities as well as other program support duties as assigned. TCTs will perform patient screening and determine the cognitive, physical, emotional and chronological development of adult and geriatric patients effecting appropriate inter/intra facility and outpatient transportation. Ensure proper operation of equipment and products by performing routine maintenance and maintaining proper records for quality reports and workload reporting. **Why is this designated as a position, this is usually a dual role for a TCT/Imager, this staff takes direction and guidance from the FTC and Administraively under the NM at the site this is for both of these.**

2.1. LICENSE AND ACCREDITATION: Contract physician(s) and all other contract licensed providers assigned by the Contractor to perform the services covered by this contract shall have a current license to practice in the state where the outpatient site is located. Including Telehealth providers. All licenses held by the personnel working on this contract shall be full and unrestricted licenses. Contract providers who have current, full and unrestricted licenses in one or more states, but who have, or ever had, a license restricted, suspended, revoked, voluntarily revoked, voluntarily surrendered pending action or denied upon application will not be considered for the purposes of this contract.

2.1.1. Technical Proficiency/Board Certification: Personnel shall be technically proficient in the skills necessary to fulfill the government's requirements, including the ability to speak, understand, read and write English fluently.

2.1.2. The Contractor must ensure that all individuals who provide services and/or supervise services at the Contractor's Outpatient Site of Care, including individuals furnishing services under contract are qualified to provide or supervise such services.

2.1.3. Contractor staff qualifications, licenses, certifications and facility accreditation must be maintained throughout the contract period of performance. In the event that Contractor's staff is not directly employed by the treating facility, documentation must be provided to the COR to ensure adequate certification. All actions required for maintaining certification must be kept up to date at all times. Documentation verifying current licenses, certifications and facility accreditation must be provided by the Contractor on an annual basis.

2.1.4. The Contractor is responsible for assuring that all persons, whether they be employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are properly licensed at all times under the applicable state law and/or regulations of the provider's license, and shall be subject to credentialing and privileging requirements by VA.

2.1.5. The Contractor shall not permit any employee to begin work at a Outpatient Site of Care prior to confirmation from the VA that the individual's background investigation has been reviewed and released to the Office of Personnel Management (OPM), by the Security and Investigations Center (SIC), and that credentialing and privileging requirements have been met. A copy of licenses must be provided with offer and will be updated annually. Any changes related to the providers' licensing or credentials will be reported immediately to the VA Credentialing Office. Failure to adhere to this provision may result in one or more of the following sanctions, which shall remain in effect until such time as the deficiency is corrected:

2.1.5.1. The VA will not pay the capitation payment due on behalf of an enrolled patient if service is provided or authorized by unlicensed personnel, without regard to whether such services were medically necessary and appropriate.

2.1.5.2. The VA may refer the matter to the appropriate licensing authority for action, as well as notify the patient that he/she was seen by a provider outside the scope of the contract and may pursue further action.

2.2. CREDENTIALING AND PRIVILEGING: Credentialing and privileging will be done in accordance with the provisions of VHA Handbook 1100.19. This VHA Handbook provides updated VHA procedures regarding credentialing and privileging, to include incorporating: VHA policy concerning VetPro; the Expedited Medical Staff Appointment Process; credentialing during activation of the facility Disaster Plan; requirements for querying the FSMB; credentialing and privileging requirements for Telemedicine and remote health care (need to ensure requirements are specific and clear); clarifications for the Summary Suspension of Privileges process in order to ensure both patient safety and practitioner rights; and the credentialing requirements for other required providers.

2.2.1. Contractor shall ensure that all Physicians, Podiatrists, Diagnostic Radiology Technologist ,Social Workers and any specialist that requires licensure or accreditation under this contract participate in the Credentialing and Privileging process through VHA's electronic credentialing system, "VetPro" No services are to be provided by any contract provider requiring credentialing until the parent VA Medical Executive Board and Director have granted approval. The Contractor shall be provided copies of current requirements and updates as they are published.

2.2.2. Credentials and Privileges shall require renewal annually in accordance with VA and TJC requirements. Credentialed providers assigned by the Contractor to work at the site shall be required to report specific patient outcome information, such as complications, to the VA. Quality improvement data provided by the Contractor and/or collected by the VA will be used to analyze individual practice patterns. The Service Chief, Primary Care Service Line will utilize the data to formulate recommendations to the Medical Executive Board when clinical privileges are being considered for renewal.

2.2.3. Contractor shall ensure that all Nurse Practitioners, Clinical Pharmacy Specialists, and Physician Assistants to be employed under this contract also participate in the Credentialing process through VA's "VetPro," in accordance with VHA Handbook 1100.19. Since Nurse Practitioners, Clinical Pharmacy Specialists, and Physician Assistants are not recognized by the VA as independent practitioners, they function under a VA Scope of Practice (not Clinical Privileges). The VA Scope of Practice must adhere to applicable practice acts within that state. The credentials and scope of practice for Nurse Practitioners, Clinical Pharmacy Specialists, and Physician Assistants are reviewed at the time of the initial appointment and at least every two years thereafter by an appropriate VA discipline-specific Professional Standards Board.

2.3. **CME/CEU**: Contractor staff registered or certified by national/medical associations shall continue to meet the minimum standards for CME to remain current. CME hours shall be reported to the credentials office for tracking. These documents are required for both privileging and re privileging. Failure to provide will result in loss of privileges.

2.4. **TRAINING (ACLS/BLS/VA MANDATORY):** Contractor staff shall complete VA mandatory training as requested and complete ACLS/BLS training and keep ACLS/BLS certifications current throughout the life of the contract. Copies of current certifications shall be provided to the COR. The contractor will coordinate and/or cover contract staff travel expenses in accordance with General Services Administration (GSA) rates. https://www.gsa.gov/portal/category/100000

2.5. **ACCESS TO PATIENT INFORMATION:** In performance of official duties, Contractor's provider(s) have regular access to printed and electronic files containing sensitive data, which must be protected under the provisions of the Privacy Act of 1974 (5 U.S.C. 552a), and other applicable laws, Federal Regulations, Veterans Affairs statutes and policies. Contractor's provider(s) are responsible for (1) protecting that data from unauthorized release or from loss, alteration, or unauthorized deletion and (2) following all applicable regulations and instructions regarding access to computerized files, release of access codes, etc., as set out in a computer access agreement which contract provider(s) signs.

2.5.1. Contractor staff shall complete the required Privacy/HIPAA training and Information Security Awareness and Rules of Behavior training and sign a VA Computer Access Agreement prior to having access to the VA computer system. Both trainings Training will be accomplished **annually**. Contractor staff shall select training modules for Privacy Training and Information Security Training. Upon completion of the training, please fax training certificates to the Contracting Officer at 615-225-3621. All contract personnel requiring access to PHI / Encrypted information must obtain a PIV to ensure secure communications from the VA (e.g. Contract billing staff requiring patient lists with PHI/PII and Contract management personnel requiring PHI/PII information).

2.5.2. In addition, if providing medical services, Contractor staff will attend CPRS training prior to providing any patient care services. Contractor staff shall document patient care in CPRS to comply with all VA and equivalent TJC standards.

2.6. **RULES OF BEHAVIOR FOR AUTOMATED INFORMATION SYSTEMS:** Contractor staff having access to VA Information Systems are required to read and sign a Rules of Behavior statement which outlines rules of behavior related to VA Automated Information Systems. The COR will provide, through the facility ISO, the Rules of Behavior to The Contractor for the respective facility.

2.7. **STANDARD PERSONNEL TESTING (PPD, ETC):** Contractor shall provide statement that all required infection control testing is current and that the contractor is compliant with OSHA regulations concerning occupational exposure to blood borne pathogens. The Contractor shall also notify the VA of any significant communicable disease exposures and the VA will also notify the contractor of the same,

as appropriate. Contractor shall adhere to current CDC/HICPAC Guideline for Infection Control in health care personnel (as published in American Journal for Infection Control- AJIC 1998; 26:289-354 http://www.cdc.gov/hicpac/pdf/InfectControl98.pdf) for disease control. Contractor shall provide follow up documentation of clearance to return to the workplace prior to their return.

2.8. NATIONAL PROVIDER IDENTIFICATION (NPI): All Contractors who provide billable healthcare services to VA; VHA, shall obtain a NPI as required by the Health Insurance Portability and Accountability Act (HIPAA) National Provider Identifier Final Rule, administered by the CMS. This rule establishes assignment of a 10-digit numeric identifier for Contractor staff, intended to replace the many identifiers currently assigned by various health plans. Contractor staff needs only one NPI, valid for all employers and health plans. Contractor staff must also designate their Specialties/Subspecialties by means of Taxonomy Codes on the NPI application. The NPI may be obtained via a secure website at: https://nppes.cms.hhs.gov/NPPES. Question - do we need to state the NPI number should correspond to the location where service is being rendered? For Example Bowling Green NPI should not show Nashville as the location but should show Bowling Green.

2.9. CONFLICT OF INTEREST: the Contractor is responsible for identifying and communicating to the CO and COR conflicts of interest at the time of proposal and during the entirety of contract performance. At the time of proposal, the Contractor shall provide a statement which describes, in a concise manner, all relevant facts concerning any past, present, or currently planned interest (financial, contractual, organizational, or otherwise) or actual or potential organizational conflicts of interest relating to the services to be provided. The Contractor shall also provide statements containing the same information for any identified consultants or sub-Contractors who shall provide services. The Contractor must also provide relevant facts that show how it's organizational and/or management system or other actions would avoid or mitigate any actual or potential organizational conflicts of interest.

2.10. CITIZENSHIP RELATED REQUIREMENTS:

2.10.1. The Contractor certifies that the Contractor shall comply with any and all legal provisions contained in the Immigration and Nationality Act of 1952, As Amended; its related laws and regulations that are enforced by Homeland Security, Immigration and Customs Enforcement and the U.S Department of Labor as these may relate to non-immigrant foreign nationals working under contract or subcontract for the Contractor while providing services to Department of Veterans Affairs.

2.10.2. While performing services for the Department of Veterans Affairs, the Contractor shall not knowingly employ, contract or subcontract with an illegal alien; foreign national non-immigrant who is in violation their status, as a result of their failure to maintain or comply with the terms and conditions of their admission into the United States. Additionally, the Contractor is required to comply with all "E-Verify" requirements consistent with "Executive Order 12989" and any related pertinent Amendments, as well as applicable Federal Acquisition Regulations.

2.10.3. If the Contractor fails to comply with any requirements outlined in the preceding paragraphs or its Agency regulations, the Department of Veterans Affairs may, at its discretion, require that the foreign national who failed to maintain their legal status in the United States or otherwise failed to comply with the requirements of the laws administered by Homeland Security, Immigration and Customs Enforcement and the U.S Department of Labor, shall be prohibited from working at the Contractor's place of business that services Department of Veterans Affairs patient referrals; or other place where the Contractor provides services to veterans who have been referred by the Department of Veterans Affairs; and shall form the basis for termination of this contract for breach.

2.10.4. This certification concerns a matter within the jurisdiction of an agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under 18 U.S.C. 1001.

2.10.5. The Contractor agrees to obtain a similar certification from its subcontractors. The certification shall be made as part of the offerors response to the RFP using the subject attachment in Section D of the solicitation document.

2.11. ANNUAL OFFICE OF INSPECTOR GENERAL (OIG) STATEMENT: In accordance with The Health Insurance Portability and Accountability Act (HIPAA) and the Balanced Budget Act (BBA) of 1977, the VA OIG has established a list of parties and entities excluded from Federal health care programs. Specifically, the listed parties and entities may not receive Federal Health Care program payments due to fraud and/or abuse of the Medicare and Medicaid programs.

2.11.1. Therefore, all Contractors shall review the OIG List of Excluded Individuals/Entities on the OIG web site at www.hhs.gov/oig to ensure that the proposed Contract staff and/or firm(s) are not listed. Contractors should note that any excluded individual or entity that submits a claim for reimbursement to a Federal health care program, or causes such a claim to be submitted, may be subject to a Civil Monetary Penalty (CMP) for each item or service furnished during a period that the person or entity was excluded and may also be subject to treble damages for the amount claimed for each item or service. CMP's may also be imposed against the Contract staff and entities that employ or enter into contracts with excluded individuals or entities to provide items or services to Federal program beneficiaries.

2.11.2. By submitting their proposal, the Contractor certifies that the OIG List of Excluded Individuals/Entities has been reviewed and that the Contractor and/or firm is/are not listed as of the date the offer/bid was signed.

2.12. NON-PERSONAL SERVICES: The parties agree that The Contractor, contract staff, agents and sub-Contractors shall not be considered VA employees for any purpose. All individuals that provide services under this resultant contract and are not employees of the Contractor shall be regarded as subcontractors. The Contractor shall be responsible and accountable for the quality of care delivered by any and all of its subcontractors. The Contractor shall be responsible for strict compliance of all contract terms and conditions without regard to who provides the service.

2.13. CONTRACT PERSONNEL: The Contractor shall be responsible for protecting all Contractor personnel furnishing services. To carry out this responsibility, The Contractor shall provide or certify that the following is provided for all contract staff providing services under the resultant contract:

Workers' compensation
Professional liability insurance
Health examinations
Income tax withholding, and
Social security payments

2.14. INHERENTLY GOVERNMENTAL FUNCTIONS PROHIBITED. This includes, but is not limited to, determination of agency policy, determination of Federal program priorities for budget requests, direction and control of government employees, selection or non-selection of individuals for Federal Government employment including the interviewing of individuals for employment, approval of position descriptions and performance standards for Federal employees, approving any contractual documents, approval of Federal licensing actions and inspections, and/or determination of budget policy, guidance, and strategy.

2.15.TORT: The Federal Tort Claims Act does not cover Contract staff. When a contract staff member has been identified as a provider in a tort claim, The Contractor's staff member shall notify the Contractor's legal counsel and/or insurance carrier. Any settlement or judgment arising from a Contractor's provider's action or non-action is the responsibility of The Contractor and/or insurance carrier.

3. HOURS OF OPERATION: The following outlines the required hours of operation: ***USE 3.1 TO 3.3 TO DESCRIBE REQUIRED SITE HOURS OR STATE THAT THEY ARE NOT APPLICABLE.)***

3.1. BUSINESS HOURS: 8am-430pm Monday through Friday, for regularly scheduled appointments.
3.2. EVENING HOURS: (Optional).
3.3. WEEKEND HOURS: (Optional)
3.4. FEDERAL HOLIDAYS: The following holidays are observed by the Department of Veterans Affairs:

New Year's Day
Washington's Birthday

Martin Luther King's Birthday
Memorial Day
Independence Day
Labor Day
Columbus Day
Veterans Day
Thanksgiving
Christmas
Any day specifically declared by the President of the United States to be a national holiday.

4. CONTRACTOR RESPONSIBILITIES:

4.1. GENERAL: Contractor performing services under this contract shall provide a continuum of care from prevention to diagnosis and treatment, to appropriate referral and follow-up. Contractor's outpatient site of care must have the necessary professional medical staff, diagnostic testing and treatment capability, and referral arrangements needed to ensure continuity of health care. The Contractor shall provide services solely dedicated to veterans regardless of gender or age. Those patients needing specialty or follow-up care shall be referred to VA. Patients referred for care outside the CBOC (e.g. VA Choice Program or similar) will be removed from the applicable billing roster the month after the patient is referred for care.

4.2. STANDARDS OF PRACTICE: Contractor shall be responsible for meeting or exceeding VA and TJC (or equivalent) standards.

4.3. PRIMARY CARE (PACT) TASKS SUMMARY: VHA HANDBOOK 1101.10 "Patient Aligned Care Team" outlines complete requirements for the PACT model. Contractor shall provide all services in accordance with the handbook. Information provided below summarizes the PACT model.

4.3.1. PACT Pillars and Foundations: The PACT delivery model is predicated on a foundation of delivering care that is patient centered, team based and continuously striving for improvement. A systems redesign approach has been developed to help teams focus on important components of the model including Patient Centered Care, Access, Care Management and Coordination as well as redesigning the team and work.

4.3.2. Enhance Patient Centered Care (PCC): Establishing a patient centered practice environment and philosophy as a core principle of PACT requires a knowledgeable staff and an engaged, activated patient and family. Contractor Clinic staff shall be required to complete the following tasks in order to begin to implement PCC:

4.3.2.1. Engage the patient/family in self-management and personal goal setting
4.3.2.2. Provide education pertinent to care needs and document the provision of that education.
4.3.2.3. Provide support on site to enroll patients in MyHealtheVet & Secure Messaging
4.3.2.4. Ensure staff is trained in self-management techniques, motivational interviewing, shared decision making as made available by VA.
4.3.2.5. Clinic patients will be notified of all normal test results within 14 days. What about abnormal? Who does the VA contact at the Contract site for after hours critical alerts/notifications?

4.3.3. Enhance Access to Care: PACT strives for superb access to care in all venues including face to face and virtual care. Achievement of the following list of requirements will assist the Contractor's Clinic in achieving superb access for Veterans.

4.3.3.1. Face to Face Visit Access: Provide same day access for patients and increase (establish) group visits and shared medical appointments Virtual Access- the contractor shall provide the following virtual access:
4.3.3.2. Telephones: Phones should be answered by a "live" person with a focus on achieving first call resolution. First call resolution is taking care of the Veteran's issue/request during that call. This approach requires thoughtful planning and strategy, Increase telephone care delivered to veterans by PACT members.
4.3.3.3. MyHealtheVet (MHV): Provide support to enroll into MyHealtheVet (MHV) and increase enrollees in MHV and Secure Messaging

4.3.3.4. Secure Messaging (SM): Encourage & educate patients to use SM as a non-synchronous mode of communication; establish SM as a communication method in clinic and increase Veteran participation in SM. 4.3.3.5. Telemedicine & Telehealth: 4.3.3.5.1. Improve access to scarce medical services via telemedicine capabilities as described in T21 Implementation Guidance document (attached in Section D). **4.3.3.5.2.** Increase Veteran enrollment in telehealth modalities available at VAMC.
4.3.4. Enhance Care Management & Coordination of Care: Improving systems and processes associated with critical patient transitions, managing populations of patients and patients at high risk has proven to have a positive impact on quality, patient satisfaction and utilization of high cost services such as acute inpatient admissions, skilled nursing facility stays, and emergency department visits. Clinic staff shall focus on the following actions to achieve improvements.
4.3.5. IMPROVE CRITICAL TRANSITIONS PROCESSES: Inpatient to Outpatient: develop systems to identify admitted primary care patients; provide follow up care either by face to face visit or telephone visit within 2 days post discharge and document the follow up care in CPRS delivered and communicate among the team.
4.3.6. ENHANCE PRIMARY CARE TO SPECIALTY CARE INTERFACE 4.3.6.1. Participate in electronic virtual consults & SCAN ECHO as available 4.3.6.2. Develop resource listing of specialty care points of contact for nursing and medical care 4.3.6.3. Participate in VAMC sponsored medical educational activities to enhance networking with specialty staff
4.3.7. ENHANCE VA & COMMUNITY INTERFACES IN CARING FOR VETERANS 4.3.7.1. Develop a list of community points of contact 4.3.7.2. Develop mutually agreeable interface systems with community facilities and providers
4.3.8. IMPROVE SYSTEMS FOR MANAGING THE CARE OF PATIENT POPULATIONS 4.3.8.1. Enhance Management of Patients with Chronic Illness 4.3.8.2. Identify patients with suboptimal chronic disease indices from VHA databases (registries) 4.3.8.3. Develop plans including staff roles and responsibilities in addressing care needs. Include all team members in delivering care as license allows. Use face to face and virtual care delivery methods such as pharmacy/nurse clinics, telephone clinic etc.
4.3.9. ENHANCE HEALTH PROMOTION & DISEASE PREVENTION FOCUS IN CARE DELIVERY 4.3.9.1. Identify patients with preventive care needs from VHA databases (registries) 4.3.9.2. Develop & implement plans including staff roles and responsibilities in addressing care needs. Include all team members in delivering care as license allows. Use face to face and virtual care delivery methods such as pharmacy/nurse clinics, telephone clinic etc.
4.3.10. ENHANCE MANAGEMENT OF HIGH RISK VETERANS: frequent emergency department visits, frequent inpatient admissions for ambulatory sensitive conditions, and severely injured/disabled, frail elderly. 4.3.10.1. Identify patients with preventive care needs from VHA databases (registries) Use of Ambulatory Care Sensitive Conditions (ACSC) to monitor and case manage this population. 4.3.10.2. Develop plans including staff roles and responsibilities in addressing care needs. Include all team members in delivering care as license allows. Use face to face and virtual care delivery methods such as pharmacy/nurse clinics, telephone clinic etc.
4.3.11. IMPROVE PRACTICE DESIGN & FLOW TO ENHANCE WORK EFFICIENCY & CARE DELIVERY: 4.3.11.1. Maximize functioning of all team members through role and task clarification for work flow processes. 4.3.11.2. Develop a plan to improve work flow process for visit or virtual care. 4.3.11.3. Conduct daily teamlet huddles to focus on operational needs for that day 4.3.11.4. Conduct weekly team meeting to focus on systems and process improvements, review and use data to monitor processes, etc.

4.4. DIRECT PATIENT CARE: 90% of the Time What does this mean, specifically?

4.4.1. REGISTRATION, ENROLLMENT, CO PAYMENTS AND EPISODIC CARE

REGISTRATION AND ENROLLMENT

CONTRACTOR RESPONSIBILITY: All veterans applying for care at the Contractor's Outpatient Site of Care shall have an application processed in VISTA by the Contractor to determine priority enrollment category for benefits. The Contractor shall process all applications for veterans requesting to be followed at the Contractor's site. The Contractor shall use a number of processes in making priority group determinations including discharge documentation, Hospital Inquiry (HINQ), and communications (written and telephonic) with the VA Regional Office and Records Management Center in St. Louis. The Contractor shall contact the VA Supervisor, Patient Registration for any unusual or complicated enrollment issues/questions. The Contractor shall adhere to the processes and guidelines established by the Supervisor, Patient Registration in regard to all issues concerning patient enrollment and registration. All applications shall be registered and enrolled into VISTA by the Contractor using the "Register a Patient" option in the VISTA Registration package. All registrations shall then be "Dispositioned" in VISTA by using the "Disposition an Application" option before close of business each day.

VA RESPONSIBILITY: Any questions related to registrations, enrollment, and dispositions can be referred to the VA Supervisor, Patient Registration at TVHBusinessOfficeEligibilityVerification-NASH@va.gov or by calling 615-873-7040.

FINANCIAL ASSESSMENTS

CONTRACTOR RESPONSIBILITY : For some veterans, an annual assessment of household income (and sometimes assets) must be completed by the veteran prior to being seen by the Contractor's provider. The Contractor shall provide a blank VA Form 10-10EZR (Renewal Application for Health Benefits) to the veteran; and the veteran will fill it out completely, including the financial information on side two of the form. The demographic and financial assessment information will be input into VISTA and maintained by the Contractor. For some veterans, a financial assessment is not required (VA pensioners, service-connected veterans receiving VA compensation, etc.).

VA RESPONSIBILITY: VA will provide the Contractor with guidelines regarding Financial Assessments, and questions can be addressed to the VA Means Test Clinic at TVHBusinessOfficeEligibilityVerification-NASH@va.gov or by calling 615-873-7040.

CO-PAYMENTS

CONTRACTOR RESPONSIBILITY: The Contractor shall notify the patient that, depending on the priority group determination, there may be a co-payment.

VA RESPONSIBILITY: A co-payment may be assessed for in-patient and outpatient services, as well as pharmaceuticals, to veterans. This co-payment is determined by priority group status and the law. All VA co-payments shall be billed and collected by the VA and are not the responsibility of the Contractor. All disputes for VA co-payments shall be referred to the Customer Service Representative for Billing at (1-888-313-5421).

ENROLLMENT VERIFICATION AND EPISODIC CARE FOR UNASSIGNED/UNENROLLED PATIENTS

CONTRACTOR RESPONSIBILITY: The Contractor shall confirm eligibility of all patients presenting for care at the Contractor's site.

Contractor shall provide at no additional cost the approximately 2/month nurse-only visits and 2/month provider visits to Veterans who are not enrolled (assigned) for care at the outpatient site of care. These visits occur when an unassigned Veteran, but who is an otherwise eligible Veteran, comes to the clinic seeking limited episodic care that cannot be provided by the Veterans assigned primary care provider/team at their preferred facility. The clinic shall ensure that the Veteran is triaged by a nurse and that any basic care that can be provided by the nurse and/or provider is provided.

Telehealth support for Patients Not Assigned at the Outpatient Site of Care— At no additional cost the contractor shall provide approximately 10/month specialty telehealth visits with the VAMC parent for Veterans who are not enrolled (assigned) for care at the Outpatient Site of Care. These visits occur when a Veteran (not assigned to the site), but who is an otherwise eligible Veteran, requires a specialty telehealth visit with the parent VAMC (vs. requiring the patient traveling to the parent VAMC). The Contractor shall support the scheduling and visit management as per requirements

and normal routine as defined in the PWS.

4.4.2. PRIMARY CARE AND MH SERVICES SCOPE OF CARE

CONTRACTOR RESPONSIBILITY: Contractor shall provide Primary Care and MH services supporting a continuum of care from prevention to diagnosis and treatment, to appropriate referral and follow-up. The Contractor shall provide each patient with a copy of a patient handbook. A sample patient handbook which the Contractor can edit to apply specifically to the Cookeville or Roane County CBOC will be provided by the parent VAMC. The handbook shall include:

Address of Contractor's Outpatient Site of Care, names of providers, telephone number(s), and office hours;
Description of services provided;
Procedures for obtaining services;
Procedures for obtaining emergency services; and
Notice to the patient that they have the right to grieve eligibility related decisions directly to the VA.

The Contractor shall be responsible for scheduling initial and/or follow-up visits to primary care providers at the Contractor's outpatient site for Simple to Moderately Complex workload that can be appropriately managed in a primary care outpatient environment as defined below**:**

Hypertension	Depression
Ischemic Heart Disease	Anxiety
Hypercholesterolemia	Degenerative Arthritis
Congestive Heart Failure	Respiratory Infection
Cerebral Vascular Disease	Chronic Obstructive Pulmonary Disease (COPD)
Peripheral Vascular Disease	Urinary Tract Infection
Diabetes Mellitus	Common Dermatological Conditions
Chronic Pain	Acute Wound Management
Gastric Disease	Skin Ulcers (Stasis and Dermal)
Anemia	Male Genitourinary (GU) Issues
Stable Chronic Hepatic Insufficiency	Cervical Cancer screening
Constipation	Osteoporosis
Common otic and optic conditions	Preventative Medicine Screening and Procedures Cervical Cancer Screening
Basic diagnostic evaluation and tests for infertility	
Breast Cancer Screening	Pharmacology in Pregnancy & Lactation
Evaluation & Treatment of Vaginitis	Evaluation of Abnormal Uterine Bleeding Menopause Symptom Management
Amenorrhea/Menstrual Disorders	
Diagnosis of pregnancy and initial screening tests	Crisis Intervention; Evaluate psychosocial well being and risks including issues regarding abuse
Evaluation and management of Acute and Chronic Pelvic Pain	Violence in women & Intimate Partner Violence Screening
Recognition and management of Postpartum Depression and Postpartum Blues	-Personal and physical abuse -Verbal/Psychological abuse
Evaluation and management of Breast Symptoms (Mass, Fibrocystic Breast Disease, Mastalgia, Nipple Discharge Mastitis, Galactorrhea, Mastodynia)	Preconception Counseling Assessment of abnormal cervical pathology

4.4.3. HISTORY AND PHYSICAL/SCREENING

CONTRACTOR RESPONSIBILITY: The Contractor shall be responsible for obtaining a complete history and physical examination which must be performed on the first visit (this is a Vesting CPT Code visit) other than in exceptional circumstances*.

~~Cervical cancer screening is not required on first visit but must be accomplished within VA screening guidelines, documenting any outside results and meeting guidelines for a new patient within the guideline time limits~~. Cervical cancer screening should be completed on the first visit, if possible. It must be accomplished within VA screening guidelines, meeting guidelines for new patients within time limits and documenting any outside results with the month, year, test results and outside provider. Comprehensive visits that include a routine Pap smear should be 60 minutes. Routine follow up appointments should be 30 minutes. A follow up visit for Pap smear only should be 30 minutes.

The complete history and physical examination shall be performed with documentation of Veteran problems via the on-line Problem List option in VISTA/CPRS computer system which shall be updated as needed on each subsequent visit.

The Problem List shall be updated by the third visit and all subsequent visits, and include all significant diagnoses, procedures, drug allergies, and medications.

* Exceptional circumstances means the Veteran is seen for his first visit as an emergency for a shorter duration visit. In this case, a complete history and physical examination must be completed within 72 hours.

4.4.4. REFERRAL FOR VA INPATIENT SERVICES

CONTRACTOR RESPONSIBILITY : The Contractor shall be responsible to contact the Transfer Coordinator at 615-873-7928/6086 to schedule admission should elective inpatient care be deemed necessary by the Contractor. (*NOTE: all inpatient care is outside the resultant contract-no costs should be charged to the resultant contract).*

Should emergency inpatient care be deemed necessary by the Contractor upon evaluation of the Veteran patient at the site, the Contractor shall first call 911 to arrange for emergency transportation to the closest facility that provides emergency care. After the emergency situation is resolved, the Contractor shall notify the VA Transfer Coordinator at 615-873-7928/6086 during normal working hours and the AOD at 615-873-7010 after normal working hours. Under no circumstances should emergent medical intervention be delayed pending administrative guidance from the VA. VA approval for emergency care is not required, but a non-VA care inpatient consult is required to be entered by the provider, after the patient has been transported to the emergency facility.

VA RESPONSIBILITY: After notification, the VA will make a determination of eligibility for payment purposes.

4.4.5. EMERGENCY RESPONSE REQUIREMENTS

CONTRACTOR RESPONSIBILITY : Persons not verified eligible who present to the Contractor in need of urgent or emergent care shall be treated on a Humanitarian basis until stable and discharged from the Contractor's Outpatient Site of Care, or referred to the proper level of care in the community. If the patient is determined to have no authorization for services, and has received care by the Contractor, the patient will be billed directly by the VA and will be informed by the Contractor that he is not eligible to continue receiving services at this site.

The Contractor shall have a local policy or standard operating procedure defining how emergencies are handled, including mental health. The Contractor shall maintain appropriate emergency response capability.

Patients who self refer to local emergency facilities and their associated charges for care are not the responsibility of the Contractor; and shall not be provided service under this contract, even if the designated Primary Care Provider under this contract is performing "on call" duties at the local facility.

If an enrolled patient who is not actually receiving care in Contractor's facility contacts the Contractor, and the Contractor believes that the veteran needs emergency care that the Contractor cannot provide, the Contractor shall advise the patient to go to the nearest emergency care facility. The Contractor shall also advise the patient that VA may not be able to pay for emergency care at the non-VA facility and that the veteran should contact the VA as soon as possible to determine if VA will pay.

If the VA is informed at the time of medical emergency (by contacting the VA Transfer Coordinator at 615-873-7928/6086, or after 4:30 PM and on weekends and holidays the Administrative Officer of the Day (AOD) 615-873-7010 and subsequent approval is granted after review of medical records, *emergency* care charges will be paid for by

the VA, generally *only* if the veteran is seen at the Contractor's site and then sent for emergency medical care at the nearest facility.

However, the Veterans Millennium Health Care and Benefits Act (38 U.S.C. 1725) (effective 5/29/00) established provisions for the possible payment of non-VA emergency services provided for non-service connected conditions of certain veterans who have no medical insurance and no other recourse for payment. Refer to 'Patient Scheduling' regarding patients who self-refer or are directed by telephone contact with the Contractor's Outpatient Site of Care to go to local emergency facilities.

Under no circumstances should emergency care be delayed pending administrative guidance from the VA.

The Contractor shall be responsible for contacting a local ambulance company if an ambulance is required to transport a patient to a local hospital for emergency care. The ambulance company shall be instructed to bill the VA for these services at the following address:

Department of Veterans Affairs

Tennessee Valley Healthcare System

Mail Stop: 136J (Attn: PTO)

3400 Murfreesboro, TN 37129

To qualify for emergency ambulance transportation, veterans must meet the following criteria: 1) he or she must be rated at least at the 50% service connected level; 2) a physician must deem the emergency ambulance transport as medically necessary and related to the service connected condition; and 3) before the transportation can take place, the veteran must receive prior approval. The Outpatient Site of Care can obtain such approval by contacting the Patient Transportation Office, Transportation Assistants at 615-225-2907. Once a decision has been made that the veteran meets the above criteria, the Contractor's physician shall complete automated VA Form 2105, *Request for Special Transportation*, **a form provided by the VA** which serves as authorization for ambulance service payment. The automated VA Form 2105 must be signed by the physician and sent to the Patient Transportation Office the same day the ambulance is requested. The Contractor shall notify the VA Transfer Coordinator at 615-873-7928/6086, or after 4:30 PM and on weekends and holidays the Administrative Officer of the Day (AOD) 615-873-7010 of the ambulance request and/or if a patient is transferred to a local hospital.

VA RESPONSIBILTY: The VA will process and respond to requests for transportation.

CONTRACTOR RESPONSIBILITY: Outpatient Sites of Care without ACLS teams are required to have an AED. The Contractor is responsible for performing the device checks and supplying monthly reports to the COR verifying that the checks are being performed in accordance with the contract requirements. Smaller sites that do not have the appropriate staff mix to manage a code need to dial 911 in addition to retrieving and using the AED. At these facilities, the Chief Medical Officer, in consultation with the code team at the VA, must determine the best location for AEDs throughout the facility. VHA Directive 2008-015, "Automatic External Defibrillators (AEDs)," dated March 12, 2008 (or subsequent revisions thereto).

VA RESPONSIBILITY: The VA will provide the Contractor with an AED and train Contractor's staff in its use and checks of the device.

4.4.6. NON-EMERGENCY TRANSPORT REQUESTS

CONTRACTOR RESPONSIBILITY: The Contractor shall be responsible for contacting the ECC at 615-225-4862 to discuss the case with the ECC physician. In addition, a brief electronic Progress Note should be entered immediately and electronically signed outlining the reason for the urgent referral to the ECC. The Progress Note should be completed in such time that the note is available for viewing by the ECC staff when the patient arrives for care. During regular business hours, the Contractor shall contact the Travel Assistants at 615-225-2904 and the Patient Transportation Office will make arrangements for either in-house or contract transfer. The Contractor's physician shall complete VA Memorandum Form 2105, *Request for Transportation*, and fax to the Travel Assistants 615-225-2907 Calls regarding non-emergent transfers occurring after normal business hours should be made to the Administrative Officer of the Day (AOD) at 615-873-7010 who will forward the call to the ECC physician. After regular business hours, the Contractor shall contact the AOD at 615-873-7010 for travel arrangements.

VA RESPONSIBILITY: VA Travel Assistants and/or AOD will respond to non-emergency transport requests**.**

4.4.7. LABORATORY SERVICES

CONTRACTOR RESPONSIBILITY: Entering orders for laboratory tests into VISTA utilizing the CPRS. Information concerning the laboratory tests is available in CPRS under the Tools Menu.

Sending specimens to the VA Core Laboratory at least once daily, no later than 2pm, unless otherwise agreed upon by the VA Core Laboratory site, *except* for those specified in this PWS.

Paying any costs of all lab work, with the exception of lab work sent to the VA or emergency lab work sent to another site which has been authorized by the VA Communications Center and paying any costs associated with transportation of specimens to the VA and for arranging such transportation in a proper secure method and ensuring that all courier service employees have completed VHA Privacy Awareness Training or equivalent. Ensuring the proper collection, collection supplies, and other preservation of specimens and providing appropriate specimen collection containers that are compatible with the instrumentation and methodology used by the VA laboratory.

Specimens must arrive at the VA in a condition that allows for safe specimen handling and not compromise the analyzers used for testing or specimen integrity. In the event that specimens are received in a container that does not satisfy those requirements, the VA reserves the right to specify the collection container to be used. A listing of specimen collection containers and laboratory test panels/profiles utilized by VA is included as an attachment to this requirement. The Contractor may not purchase the specimen collection containers from the VA since Federal Acquisition Regulations prohibit the purchase of supplies for resale. Specimens with a shipping manifest shall be delivered to the VA laboratory receiving area, located at the TVHS York campus in Murfreesboro, TN. Instructions for specimen collection, specimen processing, shipping manifest, and packaging of specimens for transport as an attachment to this requirement. The VA will not be responsible for the quality of laboratory test results obtain from specimens improperly collected or labeled, processed (centrifuged and aliquoted) and/or transported by the Contractor. The Contractor shall be contacted to resolve any discrepancies identified on the shipping manifest. The Contractor shall be notified of any specimen or testing problems. All laboratory test results will be available through VISTA/CPRS upon completion. The **Pathology and Laboratory Program Laboratory Information Manual** is available through CPRS/Tools/Lab Information, electronically (attached), or hardcopy. Questions regarding VA laboratory services shall be addressed to the VA Chief Medical Technologist at TVHS York campus in Murfreesboro, TN.

If laboratory services to be provided under this resultant contract are not performed at Contractor's site, the Contractor shall be responsible for transporting laboratory samples in a manner to ensure the integrity of the specimens and proper safeguarding of protected health information. The Contractor shall supply any special preservatives required for specimen preservation. Frozen specimens shall be shipped on dry ice, if required. If laboratory services are performed at a site other than the VA, the Contractor is responsible for entering the laboratory results into VISTA. The results for laboratory tests performed at another site cannot be entered into VISTA using existing test files. The Contractor must contact the Pathology and Laboratory Manager at TVHS York campus in Murfreesboro, TN to create new test files prior to entering results.

Does the contract CBOC have to draw labs for unassigned Veteran? Example, Veteran obtains PC in Nashville but lives in Dover. Can the VA place a Lab order at Dover CBOC, so Veteran doesn't have to travel to Nashville for labs? Is there a policy requiring or can the contract be worded to accommodates this situation?

4.4.8. POINT OF CARE TESTING SERVICES

CONTRACTOR RESPONSIBILITY: Mandated POC testing includes: glucose testing, urine pregnancy testing, O2 saturation testing, and certain STD testing shall be provided, including testing for Chlamydia and gonorrhea.

Pregnancy testing. ~~Outpaitent~~ Outpatient Site of Care must have point of care or stat pregnancy testing at the same site of care.

Conditions requiring chronic anticoagulation with warfarin. All Outpatient Sites of Care shall perform POCINR testing to allow for real time adjustment of warfarin dosing. The management of all chronic anticoagulation for patients on warfarin shall be centralized to no less than a designated mid-level provider at the Contractor's location.

Glycosylated Hemoglobin (HbA1C) testing for patients with diabetes. Several VA Mission Critical performance targets are based on HbA1C levels in diabetics, including yearly monitoring of HbA1C levels. This POC testing shall be performed at least yearly. This testing must be performed using testing methodologies which meet the standards of

care for precision and accuracy as determined by VA.

The laboratory tests designated as waived under the Clinical Laboratory Improvement Amendments of 1988 and all amendments (CLIA'88, et al.), 42 CFR 493.15(b) and 493.15(c). In the CLIA regulations, waived tests were defined as simple laboratory examinations and procedures that are cleared by the FDA for home use; employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; or pose no reasonable risk of harm to the patient if the test is performed incorrectly. In order to perform these tests, The Contractor must apply for and maintain a current VA CLIA Certificate. The application for the VA CLIA Certificate, obtained from the Chief Medical Technologist, is sent to the National Enforcement Office who issues the CLIA Certificate.

In addition, the Contractor must apply for and maintain a Tennessee Department of Health Level II Clinical Laboratory Permit. In the performance of these tests, the Contractor must comply with the terms and requirements of the Ancillary Testing Policy, MCM 626-12-113-03, Ancillary Testing Program. The Ancillary Testing Policy is available electronically or by hardcopy.

The Contractor must adhere to the VA (as detailed in VA handbook 1106.1) standards/requirements when performing waived laboratory tests. The results of all waived testing must be entered into the medical record through the laboratory software package in VISTA or CPRS template notes. The Contractor must take immediate action on any critical waived test result and immediately inform the VA, document the action taken through CPRS. It is the Contractor's responsibility to maintain the test systems/instruments in proper working order. When necessary, the Contractor must send quality control records and test results to the Ancillary Testing staff for the purpose of troubleshooting test system/instrument malfunction. The Contractor must address all questions concerning waived point of care testing to the Ancillary Testing staff at 615-225-4688 or 615-873-8209

4.4.9. WAIVED TESTING REQUIREMENTS

VA RESPONSIBILITY: The VA will provide the test systems/instruments and reagents for contractor waived testing with the exception of fecal occult blood testing cards and developer FIT Occult Blood Testing Program. The Contractor must contact the VA Ancillary Testing staff prior to purchasing fecal occult blood test kits to ensure consistency of methodology/ manufacturer. If the VA changes fecal occult blood testing methodology/ manufacturer, the Contractor must comply with the change to maintain the same standard of care. All of these test systems/instruments are from manufacturers that have received 510(K) clearance from the FDA. The VA will provide test procedures and training materials, initial training, and annual competency assessment. The Ancillary Testing staff will make periodic visits to the Contractor's site and monitor the quality control and test results to ensure accuracy and, consistency, and adherences to VA policies and requirements.

All waived testing at the Contractor's site will be under the oversight of the VA Ancillary Testing Program. The Contractor is required to use the same test systems/instruments; quality control and reagent lot numbers used for waived testing performed at the VA. When the VA Ancillary Testing Program upgrades waived test systems/instruments, the VA will furnish the Contractor with the new test systems/instruments to maintain the same standard of care. The Ancillary Testing staff will arrange for repair/maintenance in the event of system/instrument failure. If required, the Contractor shall provide a courier to transport instruments and/or reagents to the Contractor or the VA Ancillary Testing staff for linearity/correlation studies and minor repairs. The VA will purchase proficiency testing materials for the Contractor, and the Contractor must comply with the Pathology and Laboratory Medicine, CAP and TJC requirements/regulations for testing proficiency materials and submitting results.

4.4.10. RADIOLOGY SERVICES

CONTRACTOR RESPONSIBILITY: Responsible for entering requests for Radiology procedures into VISTA utilizing CPRS. All imaging orders shall be clinically appropriate. X-rays shall be performed by the Contractor on site at the outpatient site of care, using Contractor provided equipment. ~~send~~ Contractor must provide FDA approved equipment that conforms to the Vista Imaging listing for *Digital Image and Communication in Medicine (DICOM)* (3.0)DICOM
http://vaww.oed.portal.va.gov/applications/VistAImaging/Lists/VistA%20Imaging%20Approved%20Equipment%20List/AllItems.aspx and
http://vaww.oed.portal.va.gov/applications/VistAImaging/Lists/Device%20Validation%20Database%20%20SharePoint%202003%20Archiv/User%20View.aspx and HL7 communications:
http://vaww.oed.portal.va.gov/applications/VistAImaging/Lists/Approved%20Devices/Approved%20HL7%20Interfaces.aspx
Images shall be stored and sent in VISTA Imaging and which is considered part of the patient's electronic record.

These images shall be a result of direct digital (DR) or computed radiography (CR) acquisition and cannot be from a DICOM film digitizer. These images shall be case edited in the Radiology VistA package by the technologists, and sent to VISTA Imaging-and PACS as defined by the VA local policy and VHA Directive RADIOLOGY PICTURE ARCHIVING AND COMMUNICATION SYSTEMS (PACS) 2011-005, within two (2) hours of completion. X-rays performed at VA or at the outpatient site of care can be viewed by the Contractor through VISTA Imaging and the PACS. Contractor is responsible for all daily/weekly quality assurance of imaging equipment as determined by the manufacturer and as required by the VA Healthcare System for repairs and maintenance of that equipment. Repairs and maintenance of equipment is the responsibility of the contractor and equipment down times can not cause delays in patient care. The Contractor shall submit a contingency plan for equipment down time, network down times, and other systems down times to ensure that timely patient care is not affected.
Patient anatomical positioning must provide optimal imaging and shall be of the highest quality control standards based on established practice standards of the ARRT. Contractor shall comply with protocols as outlined by the parent facility's Radiology Service. Protocols are identified in the TVHS Medical Imaging Service Policy and Procedure Manual and available by contacting the Administrative Officer, Radiology at TVHS Nashville campus.

4.4.11. INTERPRETATION OF RESULTS

VA RESPONSIBILITY: X-rays will be interpreted by VA Radiologists at the TVHS York campus in Murfreesboro, as defined by VA local policy within one (1) working day of receipt. X-ray interpretation reports will be available in VA' s VISTA/CPRS computer system within two (2) working business days of receipt. The VA Radiology Program Service may be contacted at 615-225-4908. The Contractor shall follow local policy and procedures as defined by TJC for any critical results or urgent results as defined by the local policy.

4.4.12. ORDERING AND REPORTING TEST RESULTS

CONTRACTOR RESPONSIBILITY: VHA Directive 2009-019, "Ordering and Reporting Test Results," dated March 24, 2009, mandates that all test results, even normal results, be reported to the patient within 14 days of when the results become available.

The Contractor shall provide the VA with the name, pager and telephone numbers of a LIP (physician, nurse practitioner, or physician assistant) at the Outpatient Site of Care to accept critical laboratory results discovered on tests done by the VA. For critical laboratory results, the LIP must respond back to the Core Laboratory within forty-five (45) minutes of the initial page or telephone call. The receiving LIP will document the results in the record and conduct a "read back" procedure to ensure accuracy of transmission and translation of all verbal results

VA will not be responsible for the failure of the Contractor to receive critically abnormal test results. For critical laboratory and x-ray results that represent an imminent danger to the patient, the Contractor shall notify the patient immediately. Critical results must be reported to the clinician by the radiologist by telephone. Documentation of this notification, "who, when" must appear in the radiology report.

For critical results that do not pose an imminent danger to the patient, the Contractor shall notify the patient within twenty-four (24) hours of receipt of the results and provide follow-up treatment within the scope of the contract. Documentation of actions taken regarding critical laboratory results and serious radiology results must be made by the Contractor in an electronic Progress Note. Requirement for Ordering Providers to have after hours contact number for reporting of critical results by TVHS medical support services.

4.4.13. ELECTROCARDIOGRAM SERVICES

CONTRACTOR RESPONSIBILITY: MUSE-compatible EKGs shall be used which are interfaced with VistA Imaging. The name and model number of the EKG machine needed is GE 5500 with modem. This will be supplied at the cost to the contractor. EKGs are done by the Outpatient Site of Care and documentation will be sent electronically from the GE 5500 EKG machine directly into VistA Imaging. When MUSE -compatible system is not available EKGs will be confirmed, interpreted and documented by the Contractor's licensed provider. The report will be scanned directly into VistA Imaging by the Outpatient Site of Care. The EKGs will be confirmed and/or read by Contractor's providers.

4.4.14. PHARMACY SERVICES (PRESCRIPTION FULFILLMENT)

VA RESPONSIBILTIY: Routine prescriptions will be dispensed by the VA and mailed to the veteran, following appropriate provider order entry in CPRS. The VA will review all submitted Nonformulary and Restricted medication consults in a timely manner, in accordance with VA policy. VA Pharmacy Service will conduct routine inspections, as per local policy. The VA Pharmacy must approve all medications and supplies stocked at the outpatient site of care location. The VA Pharmacy will provide the Contractor with a limited supply of routine vaccines for administration

when a VA supplied Pyxis machine is on-site. An order for the vaccine must be entered into CPRS by the provider. Mandatory Training Requirements must be completed prior to a Pyxis being placed at a contract site. With having nurses (RNs) provide certain vaccines by TVHS nursing protocol and without provider order, should this statement be qualified? I just confirmed with Sarah Wiseman that the protocols do apply to contract cboc nurses.

CONTRACTOR RESPONSIBILITY: The Contractor will provide all medications, including any necessary vaccines that are to be administered to patients in the clinic. The Contractor will also provide all acutely needed medications, up to a 10-day supply, where required for appropriate patient care. The Contractor must abide by all Joint Commission and VA policy on the storage, security and handlings of all medications held in their clinic and comply with all monthly ward inspections and the recommendations generated from those inspections, as conducted by VA Pharmacy Service. The Contractor must keep all vaccines furnished by the VA separated from all other pharmaceuticals, in a secure and locked location, refrigerated and monitor temperatures of vaccines and other refrigerated drugs on a twice daily basis per TJC and CDC guidelines for vaccines. A record of refrigerator temperature monitoring must be maintained by the contractor. If a temperature variation is identified by the contractor, the contractor should contact the VA immediately to determine the appropriate disposition for the refrigerated medications. Vaccines, medications and supplies furnished to the Contractor by the VA are only to be used for VA patients. To monitor the use of VA provided items, the Contractor must develop an electronic log for each VA-furnished item. The contractor must not accept, store or distribute pharmaceutical samples and storage of pharmacy items must meet VA policy requirements. Regarding use of pyxis, the contractor requirement paragraph is contradictory, stating that all vaccines have to be separate in a temperature-controlled refrigerator. I understand there are pyxis modules that allow for temp-sensitive medication dispensing (and meet CDC guidelines for vaccines), but not sure if that is what is planned.

4.4.15. PHARMACY SERVICES

CONTRACTOR RESPONSIBILITY: Shall be responsible for prescribing medications as needed. Prior to prescribing any medications, the Contractor shall review medication profiles in CPRS for duplicate therapy, drug-disease complications, drug-drug, drug-food, drug-lab interferences, appropriateness of dose, frequency and route of administration, drug allergy, clinical abuse/misuse, and documentation of medications obtained outside of the VA in CPRS "Non-VA" medications list, including over-the-counter and herbal agents and known allergies.

The Contractor is required to enter all prescription orders using the CPRS outpatient medication order entry option. The Contractor must include complete directions for the prescription ("PRN" alone is not acceptable), the indication and frequency for the medication use ~~(whenever possible)~~, the appropriate quantity, and subsequent refills for the medication. Providers will comply with all local Medication Management policies in the prescribing of medications.

Medication orders for all controlled substances prescriptions ~~(Schedule II)~~ prescriptions must be entered into CPRS (as per local policy) using the appropriate e-prescribing process (e.g., PIV card) ~~and transmitted to the VA Pharmacy at the end of each business day~~. In event of computer down-time, written prescriptions (on an authorized VA Form 10-2577F or other State or Federally approved controlled substance order form) must be used and shall be couriered, signature confirmed, to the VA Pharmacy-designated point of contact at the end of each business day. The VA will dispense controlled substances in accordance with Federal Law CFR Title 21 1300-end. It is fully expected that all providers will maintain active PIV cards at all times in order to comply with required prescribing guidelines on controlled substances, as applicable.

The Contractor is required to utilize the VA National Formulary ~~drug formulary~~. The formulary is available electronically under Drug File Inquiry in the VISTA physician package. Non-formulary and Restricted medications ~~drugs~~ are ~~also~~ marked "NF" or "Restricted" in the CPRS drug file. Changes to the formulary affecting ~~effecting~~ prescribing will be sent to the Contractor electronically through Outlook messages. Non-formulary or restricted medications may be reviewed for approval with appropriate clinical justification by utilization of the electronic non-formulary/restricted medication consult request process in CPRS. ~~can be obtained with appropriate clinical justification by utilization of the electronic non-formulary medication order form in CPRS~~. The Contractor is required to follow national ~~and local~~ VA guidelines for the use of non-formulary or restricted medications, and to support evidence based VA ~~pharmacy~~ cost savings initiatives undertaken by the local VA. These guidelines may ~~can~~ be accessed in CPRS through the Tools menu, Web links, Pharmacy Benefits Management website or directly through the PBM website at VA National Formulary. The Contractor is required to adhere to ~~the local~~ VA Dual Care Policy.

~~The VA Pharmacy will work closely with the Contractor in prompt mailing of medications. Should the provider determine that it would be detrimental to the patient's health to wait 7-10 days before initiating drug therapy, the~~

~~provider may write a prescription (based on a limited formulary of emergent need items attached) for a bridge supply of the drug to be filled at the local contracted pharmacy vendor until the prescription can be processed and mailed from VA Pharmacy.~~

NOTE: The provider must enter documentation in the NonVA medication section of CPRS for any medication(s) issued to private pharmacies for dispensing to VA patients. ~~**an order for the drug in CPRS as with documentation that the medication was filled locally.**~~

A patient's new allergy information shall be entered into the patient's record via CPRS. The specifics of the patient's allergy or adverse drug reaction, if known, must be included in the documentation. VA Pharmacy is not permitted to dispense any prescriptions without documentation of a patient's allergies being listed in the chart (or documentation that no known allergies exist as appropriate).

All medications and supplies used in the treatment of outpatients on premises are required to be stored and secured to meet compliance with The Joint Commission (TJC) standards, VHA policy, and OSHA guidelines. Efforts should be made to limit the number of ward stock medications and supplies stored at the Outpatient Site of Care. The Contractor is responsible to ensure all medications are subject to routine inspection, as required by VA Pharmacy and meet all VA policy and TJC standards for medication management.

In accordance with TJC standards, the Contractor shall actively participate in routine inspections in collaboration with the local VA Pharmacy on a VA-specified regular basis. All medication storage sites will be inspected to ensure that medications are being stored properly (e.g., under appropriate refrigeration, if required; externals separated from internals; expiration dates checked, etc.) and VA Medication Inspection Form (VA Form 10-0053) will be completed, signed by the inspecting Pharmacy personnel and the Clinic Nurse Manager. This information will be used in conjunction with the COR's quarterly evaluation of the Contractor's performance. Follow-up on all recommendations identified and resolution of all identified discrepancies on the Medication Inspection Form will be completed in a timely manner by Clinic Personnel.

The Contractor shall be responsible for providing all necessary information for each provider with prescriptive authority to the VA Credentialing Office (or as designated by the local VA).

New drug orders: The contractor shall ensure that at least 95% of all new drug order requests follow all VA National Formulary prescribing guidelines.

The Contractor shall provide medication counseling to patients, family or caregivers in accordance with State and Federal laws and VHA requirements, including, but not limited to:

Medication instructions regarding drug, dose, route, storage, what to do if dose is missed, self-monitoring drug therapy, precautions, common side effects, drug-food interactions, and medication reconciliation, and importance of maintaining an accurate and up-to-date list of all medications (including herbals and over-the-counter medications), along with any verbal and/or written instruction provided. Confirmation and documentation of patient/caregiver instruction and the patient's/caregiver's understanding of the instructions including telephone contacts must be documented in CPRS Progress Notes.

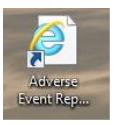
Instructions of VA refill process (VA patient handout).

Instructions to veterans and/or caregiver on the safe and appropriate use of medication-related equipment being supplied shall be documented in the veteran's medical record.

Instructions on Coordinated Care for Traveling Veterans (or subsequent revisions thereto).

Instructions on VA National Dual Care Policy (or subsequent revisions thereto).

Reports of Adverse Drug Events (ADEs) will be documented in the patients' medical record (under the Allergy/Adverse Drug Reaction tracking option in CPRS), with the specifics of the event documented as outlined in local VA policy and the Adverse Event Reporting program on all TVHS desktops.



All medication errors and medication-related incidents shall be reported immediately to the Chief, Pharmacy Service or designee and submitted to the local VA Patient Safety on the local VA-approved Incident Report form.

Customer complaints regarding pharmacy services must be addressed by the VA Pharmacy Service. Reports of such complaints must be recorded and forwarded to the VA Chief, Pharmacy Service on a routine and timely basis.

The Contractor must work in collaboration with VA Pharmacy Service when there are identified unique medication management needs of the patients and submit appropriate Nonformulary/Restricted CPRS consults where appropriate for further review. Examples of this include notification and management of patients that are taking medications that pose a medication safety concern or patients that are taking medications that require therapeutic substitution based on formulary or medication safety concerns. Contractor requirements will be further identified by VA governing bodies and VA Pharmacy.

In accordance with TJC regulations, the Contractor shall provide the patient with an accurate, reconciled list of medication to include medications that the patient is receiving from the VA, medications that he takes from non-VA providers, and any OTC, herbal or alternative medications that the patient reports taking. The Contractor shall meet all requirements of Medication Reconciliation (or subsequent revisions thereto) as well as any VA policy related to medication reconciliation. The Contractor shall also provide monthly monitors to FILL-IN or compliance with Medication Reconciliation per Medical Center Memorandum (ENTER LOCAL POLICY AT YOUR FACILITY) which can be obtained from the Chief, Pharmacy at FILL-IN.

The Contractor shall meet all requirements for anticoagulation management outlined in Anticoagulation Therapy Management (or subsequent revisions thereto) as well as VA policy related to the management of patients on anticoagulation. The Contractor shall provide Quarterly and annual anticoagulation quality assurance summaries as outlined by the local Pharmacy & Therapeutics Committee. For questions, please contact, POC, VA Anticoagulation Coordinator @ name@va.govname@va.gov@

~~Medications determined by the provider to be emergent but NOT on the emergent formulary list must be pre-approved by VA pharmacy service prior to being filled at the local contracted pharmacy vendor (Check with PBM website at http://www.pbm.va.gov/PBM/NationalFormulary.asp). Authorization must occur BEFORE sending the patient to the local pharmacy to ensure the prescription will be filled. The VA EMERGENT DRUG FORMULARY should NOT be used to bridge refills for the patient (i.e. used to give partials until refills are processed).~~

~~Upon dispensing or administration to a VA patient, the Contractor shall enter in the log the first initial of the patient's last name, the patients first name (to avoid confusion between patients with the same last name), the last four digits of patient's SS #, date, vaccine name, and quantity. The electronic log book will reside on a VA shared drive or SharePoint site. No paper based log books are to be maintained for any reason. When nearing depletion, the supply of vaccines provided to the Contractor shall be replenished by VA upon faxing a copy of the appropriate properly completed log to the TVHS Inpatient Pharmacy Supervisor. Influenza, pneumococcal, tetanus/diphtheria toxoid, with and without pertussis (TD/TDaP), Herpes zoster, human papilloma virus, and PPD will be stocked at the Contractor's Outpatient Site of Care. The more expensive, less routine vaccines will not be stocked, but must be ordered by prescription for the specific patient.~~

~~A patient's new allergy information shall be entered into the patient's record via CPRS. The specifics of the patient's allergy or adverse drug reaction, if known, must be included in the documentation. VA Pharmacy is not permitted to dispense any prescriptions without documentation of a patient's allergies being listed in the chart (or documentation that no known allergies exist as appropriate).~~

~~All routine medications and supplies used in the treatment of outpatients on premises are required to be stored and secured to meet compliance with TJC standards, VHA policy, and OSHA guidelines. Efforts should be made to limit the number of ward stock medications and supplies stored at the Outpatient Site of Care. The Contractor is responsible to ensure all medications are subject to routine inspection, inventory as required by VA Pharmacy, proper storage (in a secure and locked location), and meet all VA policy and TJC standards for medication management.~~

~~In accordance with TJC standards, the Contractor shall conduct nursing station inspections in collaboration with the local VA Pharmacy on a monthly basis (with oversight provided by VA Pharmacy and governing bodies). The medication storage sites and clinic nursing station will be inspected to ensure that medications are being stored properly (i.e. under refrigeration, if required; externals separated from internals; expiration dates checked, etc.), and VA Medication Inspection Form (VA Form 10-0053) will be completed and mailed to the VA Outpatient Pharmacy Supervisor and the COR by the tenth (10th) day of each month. This information will be used in conjunction with the~~

~~COR's quarterly evaluation of the Contractor's performance. The VA will provide the Contractor with a supply of VA Form 10-0053. The mailing address is:~~

~~VA Tennessee Valley Healthcare System~~

~~Pharmacy Service (626/119N)~~

~~Attn: Chief, Pharmacy Service~~

~~1310 24th Ave. South~~

~~Nashville, TN 37212~~

~~The Contractor shall be responsible for providing all necessary information for each provider with prescriptive authority to VA medical center office/service responsible for entering provider data, to include a signature documentation that includes the prescribers name, state license information, DEA number (as applicable), address, phone number and the original prescribers "wet signature."~~

~~New drug orders: The contractor shall ensure that at least 95% of all new drug order requests follow all TVHS prescribing guidelines. This is including but not limited to ensuring all appropriate labs have been previously ordered and that the order is not a non-formulary drug.~~

~~The Contractor shall provide counseling to patients, family or caregivers in accordance with State and Federal laws and VHA requirements, /family, including, but not limited to:~~

~~Medication instructions regarding drug, dose, route, storage, what to do if dose is missed, self-monitoring drug therapy, precautions, common side effects, drug-food interactions, and medication reconciliation, and importance of maintaining an accurate and up-to-date list of all medications (including herbals and over-the-counter medications). (Verbal and/or written instruction). Confirmation and documentation of patient/caregiver instruction and the of patient's/caregiver patient's understanding of the instructions including telephone contacts must be documented in the Progress Notes or by using a template provided for this purpose.~~

~~Instructions of VA refill process (VA patient handout).~~

~~Instructions to veterans and/or care giver on the safe and appropriate use of equipment being supplied shall be documented in the veteran's medical record.~~

~~Instructions on VHA Directive 2007-016 "Coordinated Care Policy for Traveling Veterans".~~

~~Instructions on VHA Directive 2009-038 "VHA National Dual Care Policy".~~

~~Reports of ADEs will be documented in the patients' medical record (under the Allergy/Adverse Drug Reaction tracking option in CPRS) and the specifics of the event must will be forwarded to VA Pharmacy as they occur via E-mail to (TVHAdverseReaction@va.gov)~~

~~All medication errors and medication related incidents shall be reported immediately to the Chief, Pharmacy Service or designee. Additionally, the Contractor shall record and report these events to prescribers and the VA Chief of Pharmacy service on a routine basis (as determined by the VA Chief, Pharmacy Service).~~

~~Customer complaints regarding pharmacy services must be addressed by the VA pharmacy service. The Contractor cannot resolve a medication related issue; the Contractor shall contact the VA Pharmacy Service to assist in resolution. Reports of such complaints must be recorded and forwarded to the VA Chief, Pharmacy Service on a routine basis.~~

~~The Contractor must work in collaboration with VA Pharmacy Service when there are identified medication management needs of the patients. Examples of this include notification and management of patients that are taking medications that pose a medication safety concern or patients that are taking medications that require therapeutic substitution based on formulary or medication safety concerns. Contractor requirements will be identified by VA governing bodies and VA Pharmacy.~~

~~In accordance with TJC regulations, the Contractor shall provide the patient with an accurate, reconciled list of medication to include medications that the patient is receiving from the VA, medications that he takes from non-VA providers, and any OTC, herbal or alternative medications that the patient reports taking. The Contractor shall meet all requirements of VHA Directive 2011-012 "Medication Reconciliation" (or subsequent revisions thereto) as well as VA policy related to medication reconciliation. The Contractor shall also provide monthly monitors to Medical~~

~~Reconciliation Subcommittee on compliance with Medication Reconciliation per Medical Center 626-14-119-16, Medication Reconciliation," which can be found on the TVHS Intranet website, under Memorandums and Policies.~~

~~The Contractor shall meet all requirements for anticoagulation management outlined in VHA Directive 2010-020 "Anticoagulation Management" (or subsequent revisions thereto) as well as VA policy related to the management of patients on anticoagulation. The Contractor shall provide Quarterly and annual anticoagulation quality assurance summaries as outlined by Drug Utilization Committee format. For questions, please contact Outlook email group, TVH Anticoagulation Subcommittee.~~

4.4.16. ~~CLINICAL~~ PHARMACY SERVICES

CONTRACTOR RESPONSIBILITY: Shall be responsible for prescribing medications as medically indicated. Prior to prescribing any medications, the Contractor shall review medication profiles in CPRS for duplicate therapy, drug-disease complications, drug-drug, drug-food, drug-lab interferences, appropriateness of dose, frequency and route of administration, drug allergy, clinical abuse/misuse, and documentation of medications obtained outside of the VA in CPRS "Non-VA" medications list, including over-the-counter and herbal agents and known allergies.

The Contractor is required to enter all prescription orders using the CPRS outpatient medication order entry option. The Contractor must include complete directions for the prescription ("PRN" alone is not acceptable), the indication and frequency for the medication use, the appropriate quantity, and subsequent refills for the medication. Providers will comply with all local Medication Management policies in the prescribing of medications.

Medication orders for all controlled substances prescriptions must be entered into CPRS (as per local policy) using the appropriate e-prescribing process (e.g., PIV card). In event of computer down-time, written prescriptions (on an authorized VA Form 10-2577F or other State or Federally approved controlled substance order form) must be used and shall be couriered, signature-confirmed, to the VA Pharmacy-designated point of contact at the end of each business day. The VA will dispense controlled substances in accordance with Federal Law CFR Title 21 1300-end. It is fully expected that all providers will maintain active PIV cards at all times in order to comply with required prescribing guidelines on controlled substances, as applicable.

The Contractor is required to utilize the VA National Formulary. The formulary is available electronically under Drug File Inquiry in the VistA physician package. Non-formulary and Restricted medications are marked "NF" or "Restricted" in the CPRS drug file. Changes to the formulary affecting prescribing will be sent to the Contractor electronically through Outlook messages. Non-formulary or restricted medications may be reviewed for approval with appropriate clinical justification by utilization of the electronic non-formulary/restricted medication consult request process in CPRS. The Contractor is required to follow all national VA guidelines for the use of non-formulary or restricted medications, and to support evidence-based VA cost savings initiatives undertaken by the local VA. These guidelines may be accessed in CPRS through the Tools menu, Web links, Pharmacy Benefits Management website or directly through the PBM website at VA National Formulary The Contractor is required to adhere to the VA Dual Care Policy.

NOTE: The provider must enter documentation in the NonVA medication section of CPRS for any medication(s) issued to private pharmacies for dispensing to VA patients.

A patient's new allergy information shall be entered into the patient's record via CPRS. The specifics of the patient's allergy or adverse drug reaction, if known, must be included in the documentation. VA Pharmacy is not permitted to dispense any prescriptions without documentation of a patient's allergies being listed in the chart (or documentation that no known allergies exist as appropriate).

All medications and supplies used in the treatment of outpatients on premises are required to be stored and secured to meet compliance with The Joint Commission (TJC) standards, VHA policy, and OSHA guidelines. Efforts should be made to limit the number of ward stock medications and supplies stored at the Outpatient Site of Care. The Contractor is responsible to ensure all medications are subject to routine inspection, as required by VA Pharmacy and meet all VA policy and TJC standards for medication management.

In accordance with TJC standards, the Contractor shall actively participate in routine inspections in collaboration with the local VA Pharmacy on a VA-specified regular basis. All medication storage sites will be inspected to ensure that medications are being stored properly (e.g., under appropriate refrigeration, if required; externals separated from internals; expiration dates checked, etc.) and VA Medication Inspection Form (VA Form 10-0053) will be completed, signed by the inspecting Pharmacy personnel and the Clinic Nurse Manager. This information will be used in conjunction with the COR's quarterly evaluation of the Contractor's performance. Follow-up on all recommendations

identified and resolution of all identified discrepancies on the Medication Inspection Form will be completed in a timely manner by Clinic Personnel.

The Contractor shall be responsible for providing all necessary information for each provider with prescriptive authority to the VA Credentialing Office (or as designated by the local VA).

New drug orders: The contractor shall ensure that at least 95% of all new drug order requests follow all VA National Formulary prescribing guidelines.

The Contractor shall provide medication counseling to patients, family or caregivers in accordance with State and Federal laws and VHA requirements, including, but not limited to:

Medication instructions regarding drug, dose, route, storage, what to do if dose is missed, self-monitoring drug therapy, precautions, common side effects, drug-food interactions, and medication reconciliation, and importance of maintaining an accurate and up-to-date list of all medications (including herbals and over-the-counter medications), along with any verbal and/or written instruction provided. Confirmation and documentation of patient/caregiver instruction and the patient's/caregiver's understanding of the instructions including telephone contacts must be documented in CPRS Progress Notes.

Instructions of VA refill process (VA patient handout).

Instructions to veterans and/or caregiver on the safe and appropriate use of medication-related equipment being supplied shall be documented in the veteran's medical record.

Instructions on Coordinated Care for Traveling Veterans (or subsequent revisions thereto).

Instructions on VA National Dual Care Policy (or subsequent revisions thereto).

Reports of Adverse Drug Events (ADEs) will be documented in the patients' medical record (under the Allergy/Adverse Drug Reaction tracking option in CPRS), with the specifics of the event documented as outlined in local VA policy and forwarded to VA Pharmacy as they occur via E-mail to FILL-IN.

All medication errors and medication-related incidents shall be reported immediately to the Chief, Pharmacy Service or designee and submitted to the local VA Patient Safety on the local VA-approved Incident Report form.

Customer complaints regarding pharmacy services must be addressed by the VA Pharmacy Service. Reports of such complaints must be recorded and forwarded to the VA Chief, Pharmacy Service on a routine and timely basis.

The Contractor must work in collaboration with VA Pharmacy Service when there are identified unique medication management needs of the patients and submit appropriate Nonformulary/Restricted CPRS consults where appropriate for further review. Examples of this include notification and management of patients that are taking medications that pose a medication safety concern or patients that are taking medications that require therapeutic substitution based on formulary or medication safety concerns. Contractor requirements will be further identified by VA governing bodies and VA Pharmacy.

In accordance with TJC regulations, the Contractor shall provide the patient with an accurate, reconciled list of medication to include medications that the patient is receiving from the VA, medications that he takes from non-VA providers, and any OTC, herbal or alternative medications that the patient reports taking. The Contractor shall meet all requirements of Medication Reconciliation (or subsequent revisions thereto) as well as any VA policy related to medication reconciliation. The Contractor shall also provide monthly monitors to FILL-IN or compliance with Medication Reconciliation per Medical Center Memorandum (*ENTER LOCAL POLICY AT YOUR FACILITY*) which can be obtained from the Chief, Pharmacy at FILL-IN.

The Contractor shall meet all requirements for anticoagulation management outlined in Anticoagulation Therapy Management (or subsequent revisions thereto) as well as VA policy related to the management of patients on anticoagulation. The Contractor shall provide Quarterly and annual anticoagulation quality assurance summaries as outlined by the local Pharmacy & Therapeutics Committee. For questions, please contact, POC, VA Anticoagulation Coordinator @ name@va.govname@va.gov.

~~Clinical pharmacy. These services shall be provided by a CPS with appropriate knowledge, skills, and abilities (KSAs) to perform comprehensive medication management as described previously. The CPS shall function in the capacity of a mid-level provider (through a VA SOP) or CPA as their primary duty is to collaborate with providers to provide comprehensive medication management to patients. VA Scope of Practice must adhere to pharmacy practice acts~~

~~within that state and the VA Chief of Pharmacy , VA Chief of Staff, and Director must work collaboratively to provide oversight for professional practice of the contracted CPS to include roles and responsibilities, VA Scope of Practice and its oversight in accordance with VHA and facility policy.~~

~~If the services are provided by the VA, the contractor shall provide space as detailed in space requirements, support staffing, and ancillary support to allow for the provision of clinical pharmacy services. The support services shall be consistent for the CPS as with other prescribers for each Contractor's scheduled clinic to include but not limited to intake vitals by LVN/LPN, Unlicensed Assistive Personnel (health tech or nursing assistant), or similar, downloading of blood sugar from meters, POC INR testing and downloading, teaching patients how to use BP monitors at home, calling patients for lab reminders, scheduling patient visits and contacting patients who no-show for rescheduling.~~

~~Direct patient care activities are essential to the role of the CPS in impacting comprehensive medication management and optimal patient care outcomes in PACT. The CPS shall have an appropriate amount bookable appointment time per week, spending 75-80% of their time in direct patient care. Direct patient care activities in PACT Pharmacy Clinics shall contain the 160 stop code in the primary or secondary position to ensure workload capture for clinical pharmacy services. As appropriate, telephone clinic shall contain appropriate stop codes as well to ensure billing and workload for clinical pharmacy services (160 in the secondary position).~~

~~Direct patient care refers to patient care functions which are carried out by a pharmacist in an advanced practice role and are above and beyond those functions considered to be routine part of a pharmacist's duties. Some examples of direct patient care activities include:Face-to-face comprehensive medication management of complex patients and chronic diseases (such as anticoagulation, hypertension, diabetes, hyperlipidemia, COPD, heart failure, hepatitis C, pain management);Urgent or same day face-to-face patient visits including but not limited to patient medication review for polypharmacy, recent hospital discharges, co-managed care patients; Virtual Care modality visits such as veteran requests through secure messaging, telephone-based care, CVT,HT; SMA; and DIGMAs.~~

VA RESPONSIBILITY: The PACT CPS and Contractor providers will receive support from VA to handle routine outpatient medication activities such as prescription verification, refill, renewal, and extension of medication, therapeutic substitutions and conversions, and other general pharmacy issues.

Core privileges shall be established in the SOP or CPS to include medication prescriptive authority, assessments, laboratory and other test ordering privileges in the most common Primary Care disease states (chronic diseases including, but not limited to, diabetes, hypertension, hyperlipidemia, smoking cessation, pain management, hepatitis C, osteoporosis).

4.4.17. TELEPHARMACY SUPPORT SERVICES

CONTRACTOR RESPONSIBILITY: The Contractor shall provide space for clinical pharmacy telehealth services at the Contractor's location as appropriate. Clinical Pharmacy services may be provided by the VA pharmacy or through the contractor depending on the location and in some instances may be provided via telehealth capabilities.

Space should provide privacy for patients to meet confidentially in an individual or group setting with providers at the VA via electronic transmissions.

Contractor shall provide clerical support, including scheduling, and ancillary support for VA telepharmacy services as appropriate. The support services should be consistent for each scheduled clinic to include but not limited to intake vitals by LVN/LPN, Unlicensed Assistive Personnel (health tech or nursing assistant), or similar, downloading of blood sugar from meters, POC INR testing and downloading, teaching patients how to use BP monitors at home, calling patients for lab reminders, scheduling patient visits and contacting patients who no-show for rescheduling. The Contractor shall facilitate use of the equipment for the veterans.

VA RESPONSIBILITY: The VA will maintain the VA-provided telehealth equipment. VA will also provide the networking capability to support the telehealth equipment.

4.4.18. PODIATRY SERVICES

Podiatry services shall be provided on site and shall focus on wellness of the foot and ankle, prevention of podiatric disease, screening for disease precursors and timely interventions and the management of existing conditions. Management includes: The diagnosis, medical, and mechanical treatment of ailments and deformities of the human foot and ankle. Surgical and more specialized podiatric cases shall be referred to the VA.

All clinical podiatry instruments, to include RME (e.g., nippers, rasps, files, knives, spatulas, scissors, mosqs, anvils, elevators, etc.), will be provided by the VA. The Contractor shall provide a sterile processing cabinet to securely store

sterilized RME at the Contractor's Outpatient Site of Care. The cabinet must have drawers/shelves and lockable doors to store and protect the sterile RME. Contaminated instruments must never be placed in or near this cabinet. The Contractor shall take reasonable precautions to maintain the RME provided by the VA and will replace any RME that is damaged or lost due to Contractor negligence.

The Contractor shall transport RME to and from the VA. All transportation and handling of the RME shall be at the Contractor's expense. Reusable burs may be included in this exchange program, as long as they are properly marked with identifying information to ensure return to the Contractor. Reusable burs must be of the type that can be steam sterilized. It is highly recommended that the Contractor uses disposable burs. Contractor personnel handling or supervising the exchange of RME must complete an Initial and Annual Competency Assessment Checklist to document understanding of the process for set-up, use, reprocessing, maintenance, and transportation of RME.

Equipment/services that shall be supplied by Contractor: Volume of instruments shall ensure contingency for SPS reprocessing delays. A ratio of an extra day supply at a minimum shall be available. For example if 20 patients are seen daily and the reprocessing of instruments takes two days and clinic runs daily, 60 instruments (20 for day one, 20 for day two and 20 in reserve in case day one's instruments are not returned in an timely manner).

- Sterile Processing Cabinet, lockable and located away from sinks
- Personal Protective Equipment (PPE) for personnel handling and using RME
- Burs (either disposable or properly marked with identifying information to ensure return to the owning site)
- Initial cleaning of contaminate RME to remove any visible soil
- Small biohazard bags (sealable baggie style) for storage of contaminated RME
- Rotation of RME on a first-in, first-out basis to ensure consistent use/rotation of equipment
- Inventory of RME to be exchanged daily with the VA SPD
- Transportation of RME to and from the VA SPD

4.4.19. PODIATRY EQUIPMENT AND STERILIZATION SUPPORT

VA RESPONSIBILITY: The Contractor's Outpatient Site of Care does not possess the required sterilization equipment and facilities necessary to comply with RME policy. Therefore, the VA SPD will sterilize all clinical podiatry RME used by the Contractor. The Contractor and VA will coordinate the daily exchange of contaminated RME with sterilized RME. The VA Sterile Processing POC can be contacted at 615-873-6050. The VA will provide:

- Sufficient RME to conduct daily exchange with VA Sterile Processing. A ratio of an extra day supply at a minimum will be provided. For example if 20 patients are seen daily and the reprocessing of instruments takes two days and clinic runs daily, 60 instruments (20 for day one, 20 for day two and 20 in reserve in case day one's instruments are not returned in an timely manner).
- Bins for transporting both contaminated and sterilized RME
- Cleaning and sterilization of instruments and burs
- Repair/replacement of any unserviceable equipment, damaged or warn due to normal wear and tear

4.4.20. SUMMARY INFORMATION FOR MENTAL HEALTH (MH) SERVICES

Estimated Veteran Workload: It is estimated that 25% of enrolled veterans will require General or Specialized Mental Health services. However, this is only an estimate based upon previous VA workload at this location, and not a guarantee of future Mental Health workload.

Mental disorders are defined as those disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (5th edition).

Contractor Responsibilities: In all MH services that the Contractor provides, the contractor shall comply with TJC and CARF and VAMC quality standards pertaining to patient treatment. Non-compliance of with these requirements may result in the revocation of clinical privileges by the VA. As defined by this contract, the Contractor's MH staff shall provide consultative advice to the primary care team, provide direct clinical care when indicated and maintain an ongoing relationship with the enrolled patient for counseling and case management of veterans with psychiatric disorders. Services to be provide include screening and prevention for mental disorders, psychopharmacology, referral for inpatient or residential care, direct care, social work, case management, group therapy, individual therapy, medication management, outreach and telemental health or arrange and manage for consultation for special emphasis

and/or complex problems (such as PTSD evidence based psychotherapy, psychological testing, military sexual trauma, or treatment of more complex diagnoses). The Mental Health staff shall also establish contact with VA if inpatient care is needed and serve as liaison between the Contractor and primary care staff to coordinate primary care and specialty mental health treatment.

Consistent with the Milliman and Robertson Criteria for Referral to Psychiatry, the contractor shall provide treatment for the less severe mental disorders within the context of the primary care contract. In the Primary Care context, the care provided by the mental health staff is primarily meant to be case management, assessment and brief treatment, for common mental conditions that can be managed in primary care (examples include uncomplicated depression, anxiety and at-risk substance use.)

The mental staff will assist the Primary Care Provider or team when a need for supportive treatment, case management or referral to community or VA resources is indicated.

Duties of all mental health staff include, but are not limited to, marshalling VA or local community resources to assist the veteran patient in meeting activities of daily living, arranging for temporary or long term residential care and/or inpatient skilled nursing care, referral to hospice services, performing in an assistive or advocacy role regarding accessing benefit programs for which the patient may be eligible, and completing assessments and providing appropriate intervention for patients suspected of being victims of neglect or abuse.

Telemental Health Services: Require a qualified professional at the facility and support staff at the distal end who can arrange appropriate time and space for the veteran, and staff who can provide technical support as needed. Use of Telemental Health to support the delivery of services is allowed and encouraged as a mechanism for meeting requirements throughout this document. Nevertheless, it is important to recognize that there may be limits to the services that can be provided using this technology. These may include certain highly interactive and "high-touch" evaluations or interventions. Sufficient band width is required for satisfactory communication. The Mental Health Service needs to consult with the medical center and VISN Information Technology Offices to determine specific requirements to have satisfactory clinical video conferencing capabilities.

Mental Health Documentation

Documentation will be complete, timely and reported in compliance with VA policies. The Progress Note must reflect the time spent with the patient and the diagnosis. Staff will also comply with all VA policies and performance measures. These include but are not limited to: Operation Enduring Freedom (OEF)/Operation Iraqi Freedom(OIF)/Operation New Dawn (OND) psycho-therapy measure, 7 Day Follow up after Mental Health Hospitalization, 24/14 Mental Health Iniatitives,14 Day evaluation and follow-up, AIMS Testing/Medication Education, clinical pathway requirements, and other measures that are determined and issued annually as part of VHA clinical standards. All patient encounters shall be documented using the VA's CPRS electronic medical record system. Mental health encounters are be completed within 5 days and progress notes are to be completed and signed/co-signed in 7 days. The staff must participate in Secure Messaging and comply with all VHA standards regarding the timeliness of responding to secure messages.

4.4.20.1 NO SHOW

No-Show Policy:

1) Regardless of High Risk status, following a No Show appointment, there shall be at least 3 attempts to contact All Veterans, and these attempts must be documented in the electronic medical record.
2) Staff shall make 3 attempts to follow up on all scheduled No Show appointments, including individual therapy, group therapy, or initial consult evaluation.
3) In most cases follow up attempts for No Show appointment are telephone calls, but it is recognized other attempts may be appropriate to the specific situation, for example homeless outreach or certified mail when there is no telephone available.
4) The telephone attempts in most cases can be conducted by any staff member who has access to document in CPRS, including clerks, LPN, health tech, etc. However, if the patient has a CPRS High Risk alert, a licensed independent provider (LIP) must make the attempts to contact the Veteran.
5) There must be a policy on No Show follow up, which includes a mechanism for supervisors to audit compliance by performing chart reviews.
6) If contact with the Veteran is unsuccessful, contacting local law enforcement for assistance is recommended when risk for harm is deemed to be imminent. Consideration for contacting local law enforcement should be based upon the documented clinical determination of imminent risk, which

applies to all Veterans regardless of High Risk status.

4.4.20.2 Primary Care Mental Health Integration Services: (PACT Expanded Team Members for Mental Health)

Contractor shall provide initial evaluation for Mental Health Services: Whenever veterans have an urgent need for mental health care, appropriate mental health services must be provided.All new and existing patients requesting or referred for mental health services must receive an initial evaluation within 24 hours. The primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs, and to trigger hospitalization or the immediate initiation of outpatient care when needed. The initial 24 hour evaluation shall be conducted by primary care, other contractor licensed mental health provider(s). The primary care mental health integration services will provide a primary care level diagnostic and treatment planning evaluation, brief psychotherapies and basic pharm- therapy services.

4.4.20.2.1 General and Specialty Mental Health Services

4.4.20.2.1.1 A comprehensive MH diagnostic and treatment planning evaluation

Must be completed within 14 days after 24 hour evaluation.

4.4.20.2.1.2 Evidence-based Psychotherapy for PTSD

All veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy as designed and shown to be effective. Provides delivery of evidence-based psychotherapy when it is clinically indicated for patients.

4.4.20.2.1.3 Evidence-based Psychotherapy for Depression and Anxiety Disorders

All veterans with depression or anxiety disorders must have access to Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Interpersonal Therapy. Delivery of evidence-based psychotherapy when it is clinically indicated for patients.

4.4.20.2.1.4 Evidence-based Somatic Therapies

(1) Evidence-based pharmacotherapy shall be provided when indicated for mood disorders, anxiety disorders, PTSD, psychotic disorders, SUD, dementia, and other cognitive disorders. Such care must be consistent withcurrent VA clinical practice guidelines and informed by current scientific literature.
(2) Care can be provided by a physician or appropriately credentialed and supervised advanced practice nurse or physician assistant, and may be provided using telemental health when appropriate.
(3) Because in many cases combined psychosocial and psychopharmacological treatment has been shown to be more effective than either intervention alone, veterans must have access to combined treatment when indicated. Pharmacotherapy needs to be coordinated with other psychosocial or psychological interventions patients may be receiving, as well as primary and other specialty medical care.

Veterans must have access to electroconvulsive therapy (ECT) in the VISN in which they receive care.
ECT must be provided when it is clinically indicated consistent with VA clinical practice guidelines found at: http://vaww.oqp.med.va.gov/CPGintra/cpg/MDD/MDD_Base.htm , as well as those of the American Psychiatric Association.
1. Staff needs to be knowledgeable about the current scientific literature.
2. Electroconvulsive therapy needs to be coordinated with other psychosocial, psychological, psychopharmacological, and medical care that patients may be receiving. (b) Patients who respond to ECT require some form of continuation or maintenance treatment to prevent relapses or recurrences.

4.4.20.2.1.5 Psychotherapy Groups

The mental health staff shall identify situations where supportive group therapy may be beneficial to veterans and their families. Groups should be time limited (10-12 sessions) and goal directed. Mental health treatments shall be

Psychotherapy groups can be closed or cohort-based, or they can continually be open to new members. There are a number of arguments in favor of closed groups. However, waiting for the formation of a new group can lead to delays in the institution of treatment. Accordingly, closed or cohort-based groups are allowable in VHA facilities only when the facility's care system ensures that they do not lead to the denial of care for any veteran, and that waiting for the start of a new psychotherapy group does not lead to delays in the implementation of care. Patients awaiting the start of a therapy group must be monitored on an ongoing basis. Their care needs must be evaluated, and alternative treatments must be implemented when needed, for example:

(a) When patients are a danger to themselves or others,
(b) When they are experiencing increasing degrees of impairment, or
(c) When they are suffering from severe symptoms.
(3) Waiting periods need to be utilized to provide pre-group preparation to enhance the experience and benefits of group treatment. Whenever patients need to wait for the start of a group, they must be offered an appropriate form of interim treatment. general and specialty mental health services when those
receiving care from the medical centers need them.

4.4.20.2.1.6 Extended MH Hours

The Contractor shall meet the following requirements for Extended Hour Clinics N/A

The VA performance standard for sites seeing more than 10,000 unique veterans each year, is to provide mental health services to those who need them during evening hours at least 1 day per week. This includes to offer services during additional evening, early morning, or weekend hours when they are required to meet the needs of the facility's patient population

4.4.20.2.1.7 MH Urgent/Emergent Services

Contractor Responsibility: If at any time a patient needs more intense services than those provided on site, the contractor mental health staff member shall take steps to arrange transfer to VA; or if more urgent care is needed, to the nearest emergency room.

During normal business hours, transfer to TVHS VAMC can be arranged by calling the Tansfer Coordinators at 615-225-4723 or 615-225-4725; and after normal business hours by calling the Administrative Officer of the Day at 615-225-4715 or 615-225-4716. The nurses or Administrative Officer of the Day will assist in arranging transfer to VA. If immediate consultation with a psychiatrist is needed, the staff can also call this number and request assistance. Patients with health-related questions may also be directed to call the Nurse Helpline at 1-800-876-7093 and follow the menu options.

4.4.20.2.1.8 Family Education and Involvement
Provide on-site Family Education, Family Consultation, Family Psychoeducation, and Marriage and Family Counseling for Veterans who need these services as part of their overall treatment.
The VA performance standard for sites treating 10,000 patients is to provide these services on-site or through contractor supported/VA provided Tele-mental health delivery.
(1) Providers need to discuss family involvement in care with all patients with Serious Mental Illness (SMI) or as clinically indicated, at least annually and at the time of each discharge from an inpatient mental health unit. The treatment plan needs to identify at least one family contact, or the reason for the lack of a contact (e.g., absence of a family, veteran preference, lack of consent). As part of this process, providers must seek consent from veterans to contact families in the future, as necessary, if the veteran experiences increased symptoms and families are needed to assist in care. If the veteran's consent is unobtainable, this must be documented.
(2) Family consultation, family education, or family psycho-education within existing statutory and regulatory counseling authority for veterans with SMI or as clinically indicated must be provided for those who need them.
(3) Opportunities for family consultation, family education, or psycho-education within existing statutory and regulatory counseling authority must be available to all veterans with SMI or as clinically indiciated.

4.4.20.2.1.9 Social Skills Training

(1) Social skills training is an evidence-based psychosocial intervention that must be provided when clinically indicated and must be available to all veterans with SMI who would benefit from it.

4.4.20.2.1.10 Peer Support Counseling

(1) The VA performance standard for sites treating 10,000 patients is the provision of individual or group counseling from peer support technicians for veterans treated for SMI when this service is clinically indicated and included in the veteran's treatment plan.
(2) The VA performance standard for sites treating <10,000 patients is to make peer counseling available for veterans with SMI when it is clinically indicated and included in the veteran's treatment plan. Peer counseling may be made available by telemental health, referral to VA facilities that are geographically accessible, or by referral to community-based providers using contract mechanisms.

4.4.20.2.1.11 Compensated Work Therapy (CWT), Transitional Work Experience, and Supported Employment

Contractor Responsibility: Provide information about the CWT Program and criteria for participation must be made available to veterans. Whether a particular patient's participation in the CWT program would be appropriate is a medical determination to be made by the responsible clinician, consistent with CWT Program criteria.

VA Responsibility: Offer CWT with both Transitional Work Experience and Supported Employment services for veterans with occupational dysfunctions resulting from their mental health conditions, or who are unsuccessful at obtaining or maintaining stable employment patterns due to mental illnesses or physical impairments co-occurring with mental illnesses. Participation in the CWT program must be available to any veteran receiving care through VA whom VA finds would benefit therapeutically from participation.

4.4.20.2.1.12 Substance Abuse Disorders (SUD)
Patient-Centered Requirements
(1) Appropriate services addressing the broad spectrum of substance use conditions including tobacco use disorders must be available for all veterans who need them.
(2) Services for tobacco-related disorders need to be provided to those who need them in a manner that is consistent with the VA-DOD Clinical Practice Guideline for Management of Tobacco Use, which can be found at: http://www.oqp.med.va.gov/cpg/TUC3/TUC_Base.htm

(a) During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for tobacco use.
(b) In addition to education and counseling about smoking cessation, evidence-based pharmacotherapy needs to be available for all adult patients using tobacco products. When provided, pharmacotherapy needs to be directly linked to education and counseling.

(3) To the greatest extent practicable and consistent with clinical standards, interventions for substance use conditions must be provided when needed in a fashion that is sensitive to the needs of veterans and of specific populations including, but not limited to: the homeless; ethnic minorities; women; geriatric patients; and patients with PTSD, other psychiatric conditions, and patients with infectious diseases (human immunodeficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and hepatitis C); TBI; and SCI.
(4) Services addressing substance use conditions can be provided in VA facilities in SUD specialty care, in primary care and other medical care settings (especially in programs that integrate mental health and primary care), through programs integrating treatment for co-occurring mental health disorders and SUD (dual diagnoses) in mental health settings, or in community settings through sharing agreements, contracts, or non-VA fee basis care to the extent that the veteran is eligible. Regardless of the setting, the process of care must recognize the principle that SUDs are, in most cases, chronic or episodic and recurrent conditions that require ongoing care.
(5) Consistent with the National Voluntary Consensus Standards for Treatment of Substance Use Conditions endorsed by the National Quality Forum (2007) and the VA-DOD Clinical Practice Guidelines for Management of Patients with SUD in Primary and Specialty Care Settings, the following services must be readily accessible to all veterans when clinically indicated.

(a) During new patient encounters and at least annually, patients in primary care, appropriate medical specialty care settings, and mental health care services need to be screened for alcohol misuse.
(b) Because population screening is not evidence-based for substance use conditions other than alcohol misuse and tobacco use; primary care, medical specialty, and mental health services need to use targeted case-finding methods to identify patients who use illicit drugs or misuse prescription or over-the counter agents. These methods need to include evaluation of signs and symptoms of substance use in patients with other relevant conditions (e.g., other mental health disorders, hepatitis C, or HIV disease).

(c) Patients who have a positive screen for, or an indication of, a substance use problem must receive further assessments to determine the level of misuse and to establish a diagnosis. Diagnostic assessment can be conducted by primary care or other medical providers, mental health providers, or specialists in substance use disorders. Patients diagnosed with a substance use illness must receive a multidimensional, bio-psychosocial assessment to guide patient centered treatment planning for substance use illness and any coexisting psychiatric or general medical conditions.

(d) All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines need to receive education and counseling regarding drinking limits and the adverse consequences of heavy drinking. When the excessive alcohol use is persistent, the patients are to receive brief motivational counseling by a health care worker with appropriate training in this area, referral to specialty providers, or other interventions depending upon the severity of the condition and the patient's preferences. For patients who are identified as dependent on alcohol, further treatment must be offered, with documentation of the offer and the care provided.

(e) All health care providers caring for an individual veteran must systematically promote the initiation of treatment and the ongoing engagement in care for patients with SUD.

1. For patients with SUD who decline referral to specialty SUD treatment, providers in primary care, mental health, or other settings need to continue to monitor patients and their substance use conditions. They are to utilize their interactions with the patient to address the substance use problems and to work with them to accept referrals. ***NOTE:*** *Strategies that may enhance motivation to seek SUD specialty care include: providing the patient easy-to-read information on the adverse consequences of drinking; having the patient identify problems that alcohol has caused; urging the patient to maintain a contemporaneous diary of alcohol use and the circumstances and consequences associated with it; and frequent appointments with the patient.* Interventions with SUD treatment-reluctant patients are always to be characterized by a high-degree of provider empathy.
2. Motivational counseling needs to be available to patients in all settings who need it to support the initiation of treatment.
3. When patients are evaluated as appropriate and are willing to be admitted to inpatient or residential treatment settings for substance use conditions, but admission to those settings is not immediately available, interim services must be provided as needed to ensure patient safety and promote treatment engagement.

(f) All contractor sites must make medically-supervised withdrawal management available by referral as needed, based on a systematic assessment of the symptoms and risks of serious adverse consequences related to the withdrawal process from alcohol, sedatives or hypnotics, or opioids.

1. Although withdrawal management can often be accomplished on an ambulatory basis, contractor sites must make inpatient withdrawal management available by referral for those who require it.
2. Withdrawal management alone does not constitute treatment for dependence and must be linked with further treatment for SUD. Appointments for follow-up treatment must be provided within 1 week of completion of medically-supervised withdrawal management.

(g) Coordinated and intensive substance use treatment programs must be available for all veterans who require them to establish early remission from the SUD. These coordinated services can be provided through either or both of the following:

1. Intensive Outpatient services at least 3 hours per day at least 3 days per week in a designated program delivered by staff with documented training and competencies addressing SUD.
2. An MH RRTP, either in a facility that specializes in SUD services or a SUD track in another MH RRTP that provides a 24/7 structured and supportive residential environment as a part of the SUD rehabilitative treatment regimen.

(h) Multiple (at least two) empirically-validated psychosocial interventions must beavailable for all patients with substance use disorders who need them, whether psychosocialintervention is the primary treatment or as an adjunctive component of a coordinated programthat includes pharmacotherapy. Empirically-validated interventions include motivationalenhancement therapy, cognitive behavioral therapy for relapse prevention, 12-step facilitationcounseling, contingency management, and SUD-focused behavioral couples counseling or family therapy.

(i) Pharmacotherapy with approved, appropriately- regulated opioid agonists (e.g.,buprenorphine or methadone) must be available to all patients diagnosed with opioid dependence for whom it is indicated and for whom there are no medical contraindications. It needs to beconsidered in developing treatment plans for

all such patients. Pharmacotherapy, if prescribed, needs to be provided in addition to, and directly linked with, psychosocial treatment and support. When agonist treatment is contraindicated or not acceptable to the patient, antagonist medication (e.g., naltrexone) needs to be available and considered for use when needed. Opioid Agonist Treatment can be delivered in either or both of the following settings: **All patients that receive Opoid Treatment must attend the Pharm-D Pain CVT Education class first before they can receive pain treatment**

1. Opioid Treatment Program (OTP). This setting of care involves a formally-approved and regulated opioid substitution clinic within which patients receive opioid agonist maintenance treatment using methadone or buprenorphine.
2. Office-based Buprenorphine Treatment. Buprenorphine can be prescribed as office based treatment in non-specialty settings (e.g., primary care), but only by a "waivered" physician. Buprenorphine is not subject to all of the regulations required in officially-identified OTPs, but must be delivered consistent with treatment guidelines and Pharmacy Benefits Management criteria for use.

(j) Pharmacotherapy with an evidence-based treatment for alcohol dependence is to be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, must be provided in addition to, and directly linked with, psychosocial treatment and support.

(k) Patients with substance use illness need to be offered long-term management for substance use illness and any other coexisting psychiatric and general medical conditions. The patient's condition needs to be monitored in an ongoing manner, and care needs to be modified,as appropriate, in response to changes in their clinical status.

(l) When PTSD or other mental health conditions co-occur with substance use disorders,evidence-based pharmacotherapy and psychosocial interventions for the other conditions need to be made available where there are no medical contraindications, with appropriate coordination of care. **CVT SUD classes can be offered to the Veteran**

(m) Substance use illness must never be a barrier for treatment of patients with other mental health conditions. Conversely, other mental disorders must never be a barrier to treating patients with substance use illnesses. When it is appropriate to delay any specific treatment, other care must be provided to address the clinical needs of the veteran.

(6). Consultations from specialists in substance use disorders or dual diagnosis must be available when needed to establish diagnoses and plan treatment.

4.4.20.2.1.13 PROGRAMS

a. To ensure the availability of outreach and referral services to homeless veterans, all contractor sites must designate at least one outreach specialist, usually a clinical social worker, to provide services to homeless veterans. ***The VA performance standard in i****n sites treating 10,000 patients is a dedicated specialist. In smaller sites serving less than 10,000, this may be a collateral assignment.*

b. All veterans who are homeless, or at risk for homelessness, must be offered shelter through collaborative relationships with providers in the community. Contractor staff must ensure that homeless veterans have a referral for emergency services and shelter or temporary housing. To the extent that it is possible under existing legal authority, facilities must facilitate the veteran's transportation to the shelter or temporary housing.

NOTE: Use of emergency shelter services should generally not exceed 3 days, and is only to be used as a last resort. Within that period of time, homeless outreach staff or other qualified clinical staff must evaluate the veteran's clinical needs, and refer or place the veteran for treatment and rehabilitation in therapeutic transitional housing, a MH RRTP, or another appropriate care setting. When longer stays in emergency shelters are unavoidable, this must be documented in the medical record; in these cases, ongoing Case Management, assessment and evaluation, and referral services must continue until more stable arrangements for transitional housing providing treatment or rehabilitation have been made.

VA Responsibilities: provide information to Contractor about collaborative formal, or informal, agreements with community providers for shelter, temporary housing, or basic emergency services and support them in working together to allow appropriate placement for veterans together with their families when they are homeless or at risk of homelessness. VA will provide information to Contractor about placement opportunities in Grant and Per Diem Program, a VA Domicilary, another VA MH RRTP, or other care settings that provide needed services. ***NOTE:***

Eligibility criteria may differ between different types of programs.

Each VA medical center that has a designated Grant and Per Diem-funded program in its area is responsible for designating a Grant and Per Diem Liaison. Each liaison is to provide case management services for Grant and Per Diem patients, and oversight of the Grant and Per Diem funded program as outlined in VHA Handbook 1162.01. Department of Housing and Urban Development (HUD)-VA Supported Housing (VASH) Programs have been established in areas that have a high concentration of homeless veterans. Through a partnership agreement, HUD provides rental assistance vouchers to homeless veterans referred by VA case management staff for permanent housing. VA provides case management and other clinical services to veterans in this program. When appropriate, the housing vouchers can be provided to veterans together with their families.

Stand Downs. Contractor is strongly encouraged to participate in parent facility run or coordinate their own Stand Downs with the parent facility annually as part of their outreach activities to homeless veterans and their families. Stand Downs are a significant part of the VA's efforts to provide services to homeless veterans. They are typically 1 to 3 day events providing services to homeless veterans such as food, shelter, clothing, health screenings, VA and Social Security benefits counseling, and referrals to a variety of other necessary services, such as housing, employment and substance abuse treatment. Stand Downs are collaborative events, coordinated between local VA facilities, other government agencies, and community agencies who serve the homeless. Mental health services including cognitive testing, diagnosis, evaluation, management of mental health and behavioral symptoms, and family consultations (when appropriate and when veterans with adequate decision-making capacity consent) must be available for all patients with TBI who may require these services.

4.4.20.2.1.14 INTEGRATING MENTAL HEALTH SERVICES IN THE CARE OF OLDER VETERANS

Services shall be provided by professionals with specific experience in mental health and aging issues. Integrated mental health services are especially critical to ensuring access, quality, coordination, and continuity of care for older veterans who are often otherwise much less likely to access mental health services. Accordingly, mental heath specialists need to be included in teams serving the needs of older veterans. The extent of staffing must be sufficient to ensure timely access to high quality, integrated care services: Psychological assessment; Cognitive evaluations; Psychological treatment services, specifically including psychosocial, environmental,and behavioral management services; and Geriatric psychopharmacology treatment services.

Contractor sites treating 10,000 or more patients must have the capacity for conducting dementia screening, diagnostic evaluations, and evidence-based interventions. When families, or significant others, are involved in care giving, the management of veterans with late life dementia needs to include education and support for them, when this is consistent with existing legal authority for including families in care processes. ***NOTE:*** *There is a robust evidence-base demonstrating that these interventions benefit the patient.*
Contractor sites treating 10,000 more more patients must have the capacity for evaluating the ability older veterans have for independent living and medical decision-making.

4.4.20.2.1.15 SPECIALIZED PTSD SERVICES

Veterans with PTSD can be treated in Specialized PTSD Services, general Mental Health Services, or primary care. All contractor sites (i.e. CBOC) must:

(1) Have the capacity to provide diagnostic evaluations and treatment planning for PTSD through full- or part-time staffing or by telemental health with parent VA medical centers.

(a) Contractor sites seeing more than 1,500 unique veterans each year must provide mental health treatment services for those who need them.

(b) When Contractor's see less than 1,500 unique veterans are within 1 hour of other VA facilities, they may make services for PTSD available to those who need them by referral to these other facilities

(c) When there are no nearby facilities, smaller contractor sites must provide needed services by telemental health, or by referral to the VA parent facility to the extent that the veteran is eligible .

(2) Make PCTs or Specialist available for consultation or care for veterans who may have PTSD, either on site, by referral to nearby VA medical centers, or by telemental health.

(a) All PTSD or Specialist programs must be able to address the care needs of veterans with both PTSD and SUD. These needs can be addressed in two ways with:

1. Distinct PTSD dual diagnosis programs or tracks that include providers with specific expertise in both PTSD and SUD, or

2. Structures, processes and formal mechanisms to support the coordination of care for PTSD with

that provided in SUD programs. These may include specialized programs of care management for these patients. Care of the intensity available in a PTSD Day Hospital or MH RRTP needs to be available to all veterans receiving care from VHA to the extent that it is clinically indicated.

4.4.20.2.1.16 SUICIDE PREVENTION

The Contractor shall follow established Medical Center policy when a positive Mental Health Screen or positive Suicide Screen is obtained. Safety plans are to be created and completed with patient input for all Veterans assigned a Suicide Behavior Flag. Veterans shall be provided with a copy of the safety plan.

TheVA performance stardard for very large sites (i.e. CBOC's) treating 10,000 patients or more is maintaining a Suicide Prevention Coordinator (SPC) with a full-time commitment to suicide prevention activities.

NOTE: *Mechanisms for support may include appointing more than one SPC, appointing care managers for high-risk patients, or providing program support assistants.*

The SPC's commitment to suicide prevention activities must include, but is not limited to:

(1) Tracking and reporting on veterans determined to be at high risk for suicide and veterans who attempt suicide;

(2) Responding to referrals from the National Suicide Prevention Hotline and other staff;

(3) Training staff who have contact with patients, including clerks, schedulers, and those who are in telephone contact with veterans, so they know how to get immediate help when veterans express any suicide plan or intent;

(4) Collaborating with community organizations and partners, and providing training to their staff members who have contact with veterans;

(5) Providing general consultation to providers concerning resources for suicidal individuals, as well as expertise and direction in the areas of system design to prevent suicidal deaths within their local VA medical centers.

(6) Working with providers to ensure that:

(a) Monitoring and treatment is intensified for high risk patients; and

(b) High-risk patients receive education and support about approaches to reduce risks.

(7) Reporting on a monthly basis to mental health leadership and the National Suicide Prevention Coordinator on the veterans who attempted or completed suicide along with requested data that is used to determine characteristics and risks associated with these groups of veterans. ***NOTE:*** *This information is tracked and trended on a national level by the Center of Excellence at Canandaigua, NY.*

ensure patient safety and in order to initiate problem-solving about any tensions or difficulties in the patient's ongoing care. The Contractor's SPC and each patient's principal mental health providers must work together to monitor high-risk patients to ensure that both their suicidality and their mental health or medical conditions are addressed.

d. Each VA medical center must establish a high risk for suicide list and a process for establishing a Category II Patient Record Flag (PRF) to help ensure that patients determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments (see current VHA policy for more detailed information).

NOTE: *Contractor site shall support and implement each component of VA's Suicide Prevention Program, and support the activities of the SPCs by ensuring they have the time and resources needed.*

4.4.20.2.1.17 PREVENTION AND MANAGEMENT OF VIOLENCE

All Contractor Staff members must meet current VA training requirements on the prevention and management of disruptive behavior.

4.4.20.2.1.18 DISASTER PREPAREDNESS

All Contractor sites must have a designated Mental Health Disaster POC, who can serve as a member of the VA parent facility's Disaster Response Team. Training for the Mental Health Disaster POC needs to be coordinated with training for other disaster response clinicians and emergency management teams at the parent facility and VISN levels.

4.4.21. MILITARY SEXUAL TRAUMA SCREENING

VHA Directive 2010-033 "Military Sexual Trauma (MST) Programming," dated July 14, 2010 (or subsequent revisions thereto) requires the expansion of the focus on sexual trauma beyond counseling and treatment, mandates that counseling and appropriate care and services be provided, and mandates that a formal mechanism be implemented to report on outreach activities. The VA has mandated screening of every veteran, male and female, for sexual trauma while in the military. This includes asking the veteran whether they have experienced sexual harassment, sexual or physical assault, or domestic violence while on active duty. All Veterans and potentially eligible individuals seen in Contractor's site's must be screened for experiences of MST. This must be done using the MST Clinical Reminder in the Computerized Patient Record System (CPRS), (see subpar. 4c(5)). Screening is to be conducted in appropriate clinical settings by providers with an appropriate level of clinical training; screenings are not to be conducted by clerks or health technicians. If a veteran screens positive for such trauma and would like to receive evaluation or counseling

services, a consult can be initiated to Behavioral Health outpatient services. The veteran may decline such services, and this should be documented as well. Immediate assistance can be obtained by calling the TVHS Military Sexual Trauma Coordinator, Cara Freudenberg, at 615-873-6110.

NOTE: Contactor sites with 5,000 or more patients must provide care for MST-related mental health conditions on-site. Contractor shall ensure that there are a sufficient number of clinicians able to provide specialized mental health care for conditions related to MST to adequately meet the demand for care.

4.4.22. RESIDENT SUPERVISION AND TEACHING

Resident Supervision/Teaching: According to the guidelines dictated by the Residency Review Committee of ACGME, the physician performing the services of the contract will be responsible for residents. Contract Provider shall be responsible for:

Academic environment: Provide for an academic environment conducive to the training and professional development for residents rotating through the VA Surgical Service in accordance with current VA and JC equivalent compliance guidelines.

Resident patient care documentation: Contractor shall be responsible for complying with the Residency review documentation and insuring that all notes and encounters are completed and shall appropriately document medical records in accordance with VA standards, equivalent to JC compliance guidelines, standard commercial practice and guidelines established by VA. The Contractor shall also perform any administrative duties relative to documentation of resident training, as required and directed by the VA COS or designated representative.

Technical Direction and Oversight: Contractor shall provide technical direction to and oversight of residents/fellows consistent with current accreditation guidelines, clinical research, protocol development, data management of protocols, quality assurance conferences and meetings, and affiliate /VA staff meetings. Ensure on-site resident supervision in accordance with the national VHA Handbook 1400.01, Resident Supervision, dated December 19, 2012. http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2847

4.4.23. TELE HEALTH SUPPORT

Contractor shall implement VHA T21 guidance for Outpatient Site of Care Telehealth

Telehealth involves the delivery of clinical care in situations in which patient and provider are separated by geographic distance. It is the responsibility of the contractor to ensure that in the event of a patient emergency, e.g. acute medical event, violence or threat of self-harm that explicit processes are in place that ensures a distance provider can alert the clinic and institute the appropriate actions to protect patients and/or staff from harm. These processes must be regularly checked to ensure they are operational and meet specified response times.

Links to VA telehealth resources that detail clinical, technology and business associated processes. These are provided for information and to guide the contractor in configuring the telehealth services that VA requires. The contractor cannot assume that all clinical, technology, business, regulatory and legal aspects of telehealth that apply to VA and VA practitioners will automatically apply to a third party contracting for telehealth-related services with VA. It is the responsibility of the contractor to ensure that all services provided by a third party to VA using telehealth meet all such requirements.

4.4.24. TELEPHONE ACCESS TO CLINICAL CARE

The Contractor must make provisions for toll free telephone care, twenty-four (24) hours a day, seven (7) days a week, including evenings, weekends and holidays, for all enrolled patients, in accordance with VHA Directive 2007-033, "Telephone Service for Clinical Care," dated 10/11/07 (or subsequent revisions thereto) located at

http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1605.

This directive establishes benchmarks for telephone service, which will be used by VA to monitor Contractor performance (e.g., call volume, abandonment rate, and average speed to answer). Benchmarks include an average speed of answer by a live person within 30 seconds and a call abandonment rate of less than 5%.

Contractor's delivering care for >5,000 patients are required to implement an automated call distribution system and report telephone metrics on the VSSC Telephone Access Database.

After Hours Telephone Care: This requirement is met if the Contractor makes arrangements with the parent VA

facility after hours WHEN call center to provide after-hours telephone access. It is recommended that the Contractor's telephone rolls over to the VA after-hours number if technology allows. If not, the after-hours telephone message should clearly provide instructions regarding access to WHEN telephone triage.

Business Hours Telephone Care: Contractor's shall 1) answer all incoming calls with a "live person" (vs. voice mail) and 2) resolve the patient's reason for calling while on the phone with the Veteran (known as First Call Resolution).

4.4.25. TELE- RETINAL SERVICES

The Contractor shall provide teleretinal imaging services for a target population of patients, to include those with Diabetes Mellitus who have not been evaluated for retinopathy within the past year, in accordance with Memorandum XX-123, "Teleretinal Imaging Program," dated 1/19/10 (or subsequent revisions thereto). The contractor's Primary Care Providers (PCPs) will determine, based on CPRS eye clinic records or patient eye history documented in CPRS, which patients that need to be imaged.

Space and Equipment requirements shall be as required by this document. TCTs shall be qualified as specified in this document.

4.4.26. TELE-DERMATOLOGY SERVICES

The Contractor shall provide medical specialty consultative services in Dermatology. VA will provide all necessary equipment and supplies, to include: specialized camera with associated memory cards, tripod, storage case, battery pack and cleaning equipment; transmission software; cleaning supplies with instructions; and rulers. The Contractor shall be required to:

Identify a mid-level provider to complete online teledermatology training through the Boston VA Medical Center and compile documents necessary to modify scope of practice and collaborative practice agreements

As requested by a Contractor PCP, utilize the trained mid-level provider to measure and photograph (using VA provided rulers and a telederm camera) potential dermatologic concerns. **We do not use midlevel providers but trained lpn/tct**

Using VA provided VistA Imaging software, utilize the trained mid-level provider or other staff member to transfer images from the telederm camera to an existing computer workstation at the Contractor's site, then transmit the images to the VA Dermatology Department for consultative analysis. **We do not use midlevel providers but trained lpn/tct**

Initiate treatment, as directed by the VA Dermatology Department.

Provide for storage of one telederm camera (and associated supplies) and the ability to move the camera to various exam rooms to take photos of potential dermatologic concerns. **Have access to an exam room and bed for privacy of the Veteran**

Clean camera, as needed, and request maintenance/repair, beyond user-level, from VA Biomedical Repair

4.4.27. NON-EMERGENT SPECIALTY CONSULTATIONS AND DIAGNOSTIC TESTS NOT PERFORMED AT THE CONTRACTOR'S SITE

Non-emergent specialty consultations and diagnostic tests not performed at the Contractor's site will be performed at the VA. Contractor shall request specialty consultations electronically through CPRS and include consult service requested, urgency, diagnosis (when required), and reason for request. Any and all additional information required by some Specialty Sections must be entered by the referring Contractor's Primary Care Provider via the consult template.

The Contractor is responsible for the coordination of the patient's primary care including referral to specialties as indicated. The VA serves as the referral center for any care or service outside the scope of this contract unless pre-authorized by the VA. The VA is responsible for communicating with the Contractor results of any treatment provided by the VA for the patient. The primary communication link will be the computerized patient record system in CPRS. Consult services available at VA via electronic request –

Medicine: Surgery: Other:

Allergy	Anesthesia	Anticoag
Autopsy Request	Bariatric Surgery	Audiology Speech
Cardiology	Cardiac Surgery	Behavioral Health
Dermatology	Colorectal Cancer	Clinical Pharmacy
Emergency Dept. Referral	Care	Community Based Care
Endocrine/Diabetes	ENT	Communication
General Medicine	General Surgery	Dental
Gastro Intestinal (GI)	Gynecology	Laboratory
Hematology/Oncology	Neurosurgery	Geriatric
Hospice (Palliative Care	Ophth/Optometry	Miscellaneous
Team)	Orthopedic	Nutrition & Weight
Infectious Disease	Plastic	Pain Management
Neurology	Podiatry	Pastoral Care
Pulmonary	Pressure	Primary Care
Renal	Ulcer/Wounds	Prosthetics
Rheumatology	Thoracic Surgery	Radiation Therapy
Therapeutic Phlebotomy	Transplant	Recreation
Vascular	(Liver/Renal)	Rehab Medicine
	Urology	Social Work
	Urogynecology	Speech Pathology

4.4.28. SPECIALTY CONSULTATIONS, DIAGNOSTIC TESTING AND CARE PROVIDED AT VA AND SITES OTHER THAN THE CONTRACTOR'S SITE

These types of services are not covered under this contract via capitation methodology and this information is for identifying the processes should specialized evaluations and treatments occur- be sure that planning identifies how services will be covered outside of this contract

The charges incurred from *non-emergent* specialty evaluations, diagnostic testing, and care provided at sites other than the VA will be the responsibility of the Contractor, unless prior authorization is obtained from the Fee Basis Section at TVHS. A request for Authorization for Outpatient Fee Basis Services is requested by the ordering Provider by completing the CPRS Generic Fee Consult with full vendor information including name, address, fax, phone and date of appointment, if the date of appointment is known. Subsequent approval may be granted upon review by the Fee Basis Approving Physician or Nurse. These authorizations, however, will be granted only in rare instances, as *non-emergent* referrals should be made to the VA.

4.4.29. WOMEN VETERANS HEALTH CARE VA Policy - Minimum of 2 VA certified Women's Health PCPs per site

The Contractor will provide mammograms for patients through a local accredited and certified mammography facility ath the contractors expense. Results of mammography screeing and diagnostic procedures must be sent to the TVHS Business Office Scanning unit to be added to the CPRS record. The TVHS Business Office Scanning unit will notify appropriate POC in the TVHS Radiology Department to assure the associated BI-RADS codes are entered into CPRS and the VISTA Radiology Package for inclusion in the VA Breast Care Registry.

The Contractor must ensure, prior to services being rendered, that the mammography facility is certified by the FDA, or a State that has been approved by FDA under 21 C.F.R. 900.21 to certify mammography facilities.

Any change in either the accreditation or certification status of a referral mammography facility will be communicated to the Radiology Chief at 615-873-6989, within one working business day after you become aware of such change. In addition, there must be a process established at each facility that ensures timely tracking and follow-up of all abnormal mammogram results. A process must be developed between Contractor and TVHS VAMC facility on receipt of

reports, images, etc. to an established POC. All reports must include the appropriate BI-RADS code including the FDA mandatory final assessment wording category.

The off-site contracted mammography facility's interpreting physician must ensure the referring VA ordering practitioner or surrogate is contacted by telephone with all critical results. Practitioner must document in radiology report when and to whom they spoke.

For results of "Suspicious" or, "Highly Suggestive of Malignancy," this communication occurs as soon as possible but no later than 3 business days after the mammogram procedure. Responsibilities for VA on-site provider notifications may be found in VHA Handbook 1105.03 (dated April 28, 2011) Hard copies of reports from sites other than the Contractor's must be scanned by the Contractor into the electronic medical record maintained at the Outpatient Site of Care. No hard copies of medical records will be maintained.

Each certified VA Mammography Program and off-site non-VHA mammography provider is required to establish a documented procedure to provide a lay summary of the written mammography report to the patient within 30 days from the date of the procedure. The documentation of letters, reports, and/or verbal communication with the patient in the patient's medical record must be in accordance with VA or MQSA standards and guidelines In accordance with VHA Directive 2009-019, Ordering and Reporting Test Results, the Ordering Practitioner, Contractor's Provider, will communicate and document the meaning of the findings, including any care plan, and/or follow up testing, within 14 days of receiving the mammogram result. (reference: 21 C.F.R 900.12(c), et.seq.).

Comprehensive primary care for women veterans is defined as the availability of complete primary care from one primary care provider at one site. The primary care provider should, in the context of a longitudinal relationship, fulfill all primary care needs, including acute and chronic illness, gender-specific, preventative and mental health care.

The full range of primary care needs for women veterans is described below: Care for acute and chronic illness includes routine detection and management of disease such as acute upper respiratory illness, cardiovascular disorders, cancer of the breast, cervix, colon, and lung, diabetes mellitus, osteoporosis, thyroid disease, COPD, etc. Gender-specific primary care, delivered by the same provider, encompasses sexuality, contraception counseling, pharmacologic issues related to pregnancy and lactation, management of menopause-related concerns, and the initial evaluation and treatment of gender-specific conditions such as pelvic and abdominal pain, abnormal vaginal bleeding, vaginal infections, etc.

Preventative care includes services such as age-appropriate cancer screening, weight management counseling, smoking cessation, immunizations, etc. The same primary care provider should screen and appropriately refer patients for military sexual trauma as well as evaluate and treat uncomplicated mental health disorders and substance use disorders.

When specialty care is necessary, the primary care provider will coordinate this care and communicate with the specialty provider regarding the evaluation and treatment plan to ensure continuity of care.

The Contractor must develop a plan to assign women ~~to an interested, proficient women veteran champion who has a sufficient number of women in their primary care panel to maintain competency in caring for those veterans~~. preferentially to the VA certified Women's Health PCPs at the contracted site. All newly enrolling women should be assigned to a Women's Health PCP. Women in panels of non-women's health PCPs should be offered the opportunity to request transfer to a Women's Health PCP at the same site of care It is recommended that women Veterans be clustered in teams where the provider and all team members have experience, knowledge and established systems of care to provide equitable, high-quality care to women Veterans. It is recommended that Women's Health PACT teamlets are assigned a panel size of at least 100 women Veterans, thus allowing all teamlet members to care for a volume of patients to support maintenance of expertist in the care of women.

In order to be initially designated as a Women's Health PCP (WH-PCP), a provider must have at least one of the following:

- Documentation of attendance at a Women's Health Mini-Residency within the previous 3 years;
- Documentation of at least 20 hours of women's health continuing medical education (CME) or continuing education unit (CEU) within the previous 3 years;
- Documentation of at least 3 years in a practice with at least 50% women patients within the previous 5

years;

- Evidence of completion of an internal medicine or family practice residency; women's health fellowship; or women's health, adult or family practice NP or PA training within the previous 3 years;
- Documentation of a current preceptorship arrangement with an experienced WH-PCP such as weekly meetings (for at least 6 months); or
- Evidence of being recognized as a known women's health leader and subject matter expert with experience practicing, teaching, and/or precepting women's health.

The Contractor must provide ongoing education and training to the ~~primary care women veteran champion~~ Women's Health Primary Care Providers to assure competency, proficiency and expertise in providing care to women veterans.

CBOCs and independent clinics must designate a women's health clinical liaison to coordinate women's health services with the Women Veterans Program Manager (WVPM) at the main facility. The liaison is usually a nurse or social worker, but may be a provider. The role of the liaison is to be the point of contact who communicate with the WVPM about issues related to women's health care, environment of care and policy, and to communicate these messages to other staff at the CBOC.

Staffing must be adequate to provide gender-appropriate chaperones as well as clinical support with availability of same-gender providers on request.

VA is authorized to provide comprehensive pre-natal, intra-partum and post-partum care to eligible women Veterans. Maternity benefits begin with the confirmation of pregnancy, preferably in the first trimester, and continue through the final post-partum visit, usually at 6-8 weeks after the delivery, when the Veteran is medically released from obstetric care. Providers must initiate ~~and Fee Basis Consult and notify the Women Veterans Program Manager at 615-873-3020~~. a Non-VA Care Maternity Consult and notify the TVHS Maternity Care Coordinator at 615-225-5535.

4.4.30. ADMINISTRATIVE: 10% of time not involved in direct patient care

Contractor's Personnel shall attend service staff meetings as required by the VA COS or designee. Contractor to communicate with COR on this requirement and report any conflicts that may interfere with compliance with this requirement.

4.4.31. SCHEDULING OF SERVICES AND **CANCELLATIONS**

Shall be responsible for scheduling office, telephone and telehealth visits with other health care providers including nurses, physician extenders, CPSs, or dietitians for the purposes of monitoring or preventing disease and providing patients with information and/or skills so they can participate in decision-making and self-care.

Shall be responsible for ensuring within twelve (12) months of the last visit, the Veteran receives a visit which justifies any of the ***Vesting CPT Codes.***

Shall be responsible for ensuring phone contacts with patients and primary care providers or their designee.

The Contract clinic is not designated as an emergency or urgent care center, and as such is by "appointment only." This appears to directly contradict Open Access and should be reviewed. Nonetheless, the Contractor shall maintain a triage system for walk-in patients. Urgent walk-in patients are to be triaged by a qualified medical practitioner.

Open Access is an important concept for VHA primary care and is in part measured by the Same Day Access metric (see Performance)

The Contractor shall meet the Veterans Health Administration's (VHA's) timeliness standards as outlined in VHA Directive 2010-027 "VHA Outpatient Scheduling Processes and Procedures," dated June 9, 2010 (or subsequent revisions to VHA Performance Standards).

Radiology appointments to be made within seven (7) calendar days of order and completed within 30 calender days of order.

Critical patients (those with true emergent needs) shall not be served by the Contractor, and shall be referred to the nearest "safe harbor" medical facility capable of providing critical emergent services. Immediate notification of the

Tansfer Coordinators at 615-225-4723 or 615-225-4725; and after normal business hours by calling the Administrative Officer of the Day at 615-225-4715 or 615-225-4716 is mandatory.

In most instances, patients shall be seen within a reasonable time of scheduled appointments in accordance with VHA standards and is included in patient satisfaction surveys.

Cancellations: Contractor shall not unnecessarily cancel patient appointments and will reschedule cancelled appointments in a timely manner. Any appointment cancelled needs to be rescheduled within 2 weeks. This means the patients must be seen within 2 weeks of the original cancelled appointment date.

No Shows: For MH Services, see MH section.

4.4.32. MY HEALTHEVET PROMOTION

Veterans interested in the My HealtheVet initiative will be directed to the web site www.myhealth.va.gov where they can register as a veteran seen at the VAHCS. Once registered, the veteran can present to the Contractor's Outpatient Site of Care to be authenticated.

4.4.33. MEDICAL RECORDS/COMPUTERIZED RECORD SYSTEMS/DISCLOSURE/RECORD RETENTION

MEDICAL RECORDS REQUIREMENTS:

Authorities: Contractor providing healthcare services to VA patients shall be considered as part of the Department Healthcare Activity and shall comply with the U.S.C.551a (Privacy Act), 38 U.S.C. 5701 (Confidentiality of claimants records), 5 U.S.C. 552 (FOIA), 38 U.S.C. 5705 (Confidentiality of Medical Quality Assurance Records) 38 U.S.C. 7332 (Confidentiality of certain medical records), Title 5 U.S.C. § 522a (Records Maintained on Individuals) as well as 45 C.F.R. Parts 160, 162, and 164 (Health Insurance Portability and Accountability Act).

The resultant contract and its requirements meet exception in 45 CFR 164.502(e), and do not require a BAA in order for Covered Entity to disclose Protected Health Information to: a health care provider for treatment. Based on this exception, a BAA is not required for this contract. Treatment and administrative patient records generated by this contract or provided to the Contractor by the VA are covered by the VA system of records entitled 'Patient Medical Records-VA'(24VA19). Contractor generated VA Patient records are the property of the VA and shall not be accessed, released, transferred, or destroyed except in accordance with applicable laws and regulations. Contractor shall ensure that all records pertaining to medical care and services are available for immediate transmission when requested by the VA. Records identified for review, audit, or evaluation by VA representatives and authorized federal and state officials, shall be accessed on-site during normal business hours or mailed by the Contractor's provider at his expense. Contractor shall deliver all final patient records, correspondence, and notes to the VA within twenty-one (21) calendar days after the contract expiration date.

The VA utilizes both a scanned and electronic medical record (EMR). The primary electronic component is the Veterans Information System and Technology Architecture (VISTA) /CPRS (Computerized Patient Record System), which consists of hardware configurations and software developed by the VA. VISTA/ CPRS, is a collection of over one hundred (100) applications that make up a comprehensive hospital information system. It includes both medical records and clinical applications or packages such as order entry, Progress Note, laboratory, radiology, scheduling/admission-discharge-transfer and discharge summary. The present VISTA/CPRS packages combined comprise an estimated 80 percent of a total electronic medical record. The scanned component of the medical record will consist only of those items not already on-line in CPRS. CPRS requires that all medical entries be done electronically, including, but not limited to, prescriptions, labs, radiology requests, Progress Notes, vital signs, problem lists, and consults.

Contractor personnel will utilize VA' current VISTA/CPRS technology to compile a concise and relevant account of the patient's health care with Contractor-owned workstation equipment and communication software.

VA will provide the necessary training to Contractor personnel on the proper use and operation of the CPRS system. VA will provide VISTA training and access appropriate to Contractor's decision to utilize clinic staff or subcontracted vendor for data entry.

Clinical Reminders: Proper documentation and completion of all clinical reminders as they appear during a patient's

visit. Standard is 90% completion of all clinical reminders monthly. VISTA/CPRS will automatically remind providers to complete the following clinical reminders during patient's visits: **Does this include placing consults to the proper services**

Alcohol Use Screen	Positive AUDIT-C Needs Evaluation	Depression Screening
Evaluation of positive PTSD	Tobacco Counseling by provider FY 18	Tobacco Counseling FY 18
Iraq and Afghanistan Post	Deployment Screening	TBI Screening
Influenza Immunization	Pneumovax	Colorectal Ca Screening
FOBT Positive F/U	Diabetes Eye Exam	Diabetes Foot Exam
Mammogram Screening	Pap Smear Screening	

Professional standards for documenting care: Care shall be appropriately documented in medical records in accordance with standard commercial practice and guidelines established by the VA. Medical record entries shall be legible and maintained in detail consistent with good medical and professional practices so as to facilitate internal and external peer reviews, medical audits and follow-up treatments. Copies of received medical information shall be authenticated (signed) copies.

The quality of medical practice shall meet or exceed reasonable standards of professional practice for the required services in health care as determined by the same authority that governs VAMC medical professionals and will be audited by the Medical Center, Service Line or other processes established for that purpose.

The Contractor shall maintain up-to-date electronic medical records at the site where medical services are provided for each member enrolled under this contract. Records accessible by the Contractor in the course of performing this agreement are the property of the VA and shall not be accessed, released, transferred or destroyed except in accordance with applicable federal law and regulations. The treatment and administrative patient records created by, or provided to, the Contractor under this agreement are covered by the VA system of records entitled "Patient Medical Records-VA" (24VA19). 24VA19 can be viewed at http://vaww.vhaco.va.gov/privacy/SystemofRecords.htm. The VA shall have unrestricted access to these records.

The contractor shall maintain electronic medical records using the computerized patient record system, CPRS, and Vista Imaging making sure they are up-to-date and will include the enrolled patient's medical records for all subcontractor providers. The electronic record shall include, at a minimum, medical information, prescription orders, diagnoses for which medications were administered or prescribed, documentation of orders for laboratory, radiological, EKG, hearing, vision, and other tests and the results of such tests and other documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of services performed or ordered under this contract. Each member's record must be electronic, which includes scanned images, will maintained in detail consistent with good medical and professional practice, which permits eDocumentation that occurs in CPRS and Vista Imaging. No documents from the electronic medical record will print and no shadow records are authorized. Effective internal and external peer review and/or medical audits facilitate an adequate system of follow-up treatment. Hard copies of external source documents may be scanned into the electronic medical record by the Contractor or a summary progress note written by an appropriate clinician after a review of the external source documents may be used in lieu of scanning any external source documents. An audit of the scanned records must be conducted by the contractor to assure they are scanned properly after scanning, and then the original documents are to be sent via UPS or other tracking service to VA Medical Records file room to be stored for 9 months and then destroyed. Scanning and audit reports will be sent via PKI encrypted e-mail to the VA File Room/Scanning Supervisor and File Room/Scanning Lead by the end of the first week of every month. No paper record shall be maintained. If there are no errors found , the Contractor shall report via email that there were no errors to be reported for the previous month.

Documentation and Clinical Records: Documentation and clinical records shall be complete, timely, and compliant with VA policies, and current Joint Commission Standards. The Contractor shall not allow its inability to access VISTA to prevent any patient from being seen by a provider. In the event, and for any reason, that the Contractor is not able to access the VISTA system, the Contractor shall record all data manually including the completion of the Encounter Form. Upon recovery of the Contractor's ability to access the VISTA system, the Contractor shall input all data recorded manually into the VISTA system within forty-eight (48) hours of the system becoming operational.

The Contractor shall report workload (check-in, check-out) within two (2) working days and other important clinical data including entry into the Patient Care Encounter (PCE module) including ICD9-CM diagnostic codes as well as CPT as defined by the American Medical Association.

The Contractor shall provide individual patient encounters (visits) workload in accordance with established VA reporting procedures. The Progress Notes for each enrolled patient visit, whether the patient visit was with the Contractor or a subcontractor, shall be entered electronically in the patient's record through the VA CPRS system.

Documentation must be complete for all fields including whether or not the patient is service connected. The CPT and provider codes must match and codes must accurately reflect complexity of visit. Complete documentation must be completed before the 18th of each month.

All Progress Notes, medication orders, and test results, applicable to services which the Contractor is responsible to provide and perform at its site or subcontractor's site, shall be entered into CPRS by the Contractor within two (2) calendar days of the patient's visit, with the exception of radiology reports.

VA Radiologist's professional interpretation of diagnostic radiology and diagnostic imaging performed by the Contractor shall be entered into VISTA/CPRS by VA. Contractor shall be responsible for entering into VA's CPRS all information and requests for laboratory and radiology test requests.

Progress Notes will be entered into CPRS or the Progress Note portion of the TIU package. The results of laboratory tests performed must be included in the Progress Notes.

Progress Notes must meet CMS guidelines for documentation which include the 3 key components to determine the level of evaluation and management (E/M). These key components include: (1) History; (2) Exam; and (3) Medical decision making. Progress Notes associated with each clinic visit will include pertinent medical treatment, a treatment plan, teaching that was provided to the patient and/or the patient's family, the date of appointment, and the electronic signature of the treating clinician.

All notes must be linked to the correct visit and location. A patient problem list must be present on the patient's record by the third clinic visit and will be entered via CPRS on the Problem List tab. This list will include all diagnoses, medications and procedures and will be updated as the patient's condition changes. Laboratory reports and results will be entered into the Laboratory Package. The process for entry of data may include manual entry or an automated procedure; however, it must adhere to applicable VA Automated Information Security (AIS) system regulations. Questions may be directed to the VA Information Security Officer at Outlook email group **VHATVHISO@va.gov**.

Encounter Forms: The Contractor shall electronically complete encounter form data in the VISTA/CPRS system within two (2) working days of visit. Completed Encounter Forms will include, but are not limited to, the Problem list, appropriate CPT code(s), a primary ICD-9 Diagnosis Code(s), designation of a primary provider, and whether the treatment or care rendered was for a service connected condition or as a result of exposure to agent orange, environmental contaminates, or ionizing radiation.

Women's Health Software Package: ~~The Contractor must utilize the Women's Health Software package to track and document preventative care for women veterans (in addition to all other VISTA requirements of this contract). Mammograms, pap smears, bone density tests and HPV vaccine administration must be ordered via clinical reminders and the results of same must be documented via clinical reminders. In addition, every mammogram ordered must be tracked. In addition to the documentation of results in the clinical record, every mammogram report received must be faxed to the Women Veterans Program Manager, at 615-873-3020~~. The Contractor should use CPRS clinical reminders and clinical records to document preventative care for women including Mammograms, pap smears, bone density tests and HPV vaccine administration. In addition, every mammogram ordered must be tracked. In addition to the documentation of results in the clinical record, every mammogram report received must be sent to the TVHS Business Office Scanning department for uploading into the CPRS clinical record.

Forms: Any new or existing Templates used by the Contractor must be approved by the VA Forms Team of Clinical Informatics Team. Request for approval shall be submitted to the forms team via e-mail VHA FORMS.

Access to VA Records: Subject to applicable federal confidentiality laws, the Contractor or its designated representatives may have access to VA records at VA's place of business on request during normal business hours where necessary to perform the duties under this resultant contract.

Reports: The Contractor is responsible for complying with all related VA reporting requirements requested by the

VA.

Availability of Records: The Contractor shall make all records available at the Contractor's expense for review, audit, or evaluation by authorized federal, state, and Comptroller or VA personnel. Access will be during normal business hours and will be either through on-site review of records or through the mail. All records to be sent by mail will be sent via UPS Ground delivery at contractor's expense to the VA within one (1) business day of request at no expense to VA.

External Peer Review Program: The Contractor shall document in the medical record preventive health case management measures and the chronic disease indicators of the enrolled patient. The medical treatment records generated by the contractor in the course of performing services under this contract shall be made available for audit by the VA's External Peer Review Program (EPRP). Medical record data must be available in CPRS and Vista Imaging and any additional records required for EPRP audit will be promptly forwarded to the VA upon request. This data will be sent **via UPS Ground delivery** at contractor's expense if necessary to meet the due date requested by the VA. EPRP is provided to the VA by other contractors. Contract providers who are seeing VA patients are considered to be the VA providers and as such are provided access to confidential patient information as contained in the medical record.

Release of Information: The VA shall maintain control of releasing any patient medical information and will follow policies and standards as defined, but not limited to Privacy Act requirements. In the case of the VA authorizing the Contractor to release patient information, the Contractor in compliance with VA regulations, and at his/her own expense, shall **use VA Form 3288, Request for and Consent to Release of Information from Individual's Records, to process "Release of Information Requests**." In addition, the Contractor shall be responsible for locating and forwarding records not kept at their facility. ~~In the case of the VA authorizing the Contractor to release patient information, the Contractor in compliance with VA regulations, and at his/her own expense, shall use VA Form 3288, Request for and Consent to Release of Information from Individual's Records, to process "Release of Information Requests." In addition, the Contractor shall be responsible for locating and forwarding records not kept at their facility.~~ The VA's Release of Information Section shall provide the Contractor with assistance in completing forms. Additionally, the Contractor shall use VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, when releasing records protected by 38 U.S.C. 7332. Treatment and release records shall include the patient's consent form. Completed Release of Information requests will be forwarded to the VA TVHS Release of Information Office, ACY Campus at 615-225-5491, or via mail addressed to TVHS, ATTN: Release of Information (136H), 3400 Lebanon Road, Murfreesboro, TN 37129.

Disclosure: Contractor and Contractor may have access to patient medical records: however, Contractor and Contractor must obtain permission from the VA before disclosing any patient information. Subject to applicable federal confidentiality or privacy laws, the Contractor, or their designated representatives, and designated representatives of federal regulatory agencies having jurisdiction over Contractor, may have access to VA 's records, at VA's place of business on request during normal business hours, to inspect and review and make copies of such records. The VA will provide the Contractor with a copy of VHA Handbook 1907.1, Health Information management and Health Records and VHA Handbook 1605.1, Privacy and Release of Information. The penalties and liabilities for the unauthorized disclosure of VA patient information mandated by the statutes and regulations mentioned above, apply to the Contractor, Contractor and/or sub Contractors.

The Contractor must provide copies of medical records, at no charge, when requested by the VA to support billing and/or VA mandated programs if these records are not available in CPRS or Vista Imaging. The Contractor shall use VA Form 5345 (release of records to outside parties), and VA Form 5345a (release of records to veterans themselves), *Request for and Consent to Release of Medical Records Protected by 38 U.S.C.,* for veterans wishing to have their records released. The Contractor shall release information in accordance with the Privacy Act of 1974, and the Health Insurance Portability and Accountability Act. Release of Information software will be used to print and release record information thus accounting for any and all disclosures of record information. The contractor shall use the provided software package DSS ROI Manager to record and account for all release of information request processed by the contractor. When releasing medical records to the veteran themselves, the 5345a form will clearly indicate:
The veteran full name and full SSN
The information that was released as authorized by the veteran
The date the information was released (inferred that date signed is date released)
Block will be checked that the information was released in person to the veteran.
When releasing the information to an outside third party, the 5345 form will clearly indicate:

- Full name of veteran and full SSN.
- Complete address of third party to who the records were released to
- The exact information that was released as authorized by the veteran
- The purpose for third party receiving the records
- The expiration date for authorization

The date the information was released, what was released, and by who shall be noted in the bottom right corner of the form in the area designated for such if software is unavailable for more than a 1 week period, the contractor shall send via UPS the signed, completed release forms clearly noting packaged material is for entry into the release of information disclosure tracking system. Complex requests, those requiring a bill or those where all the information may not be available to the Contractor, will be forwarded via fax to the VA TVHS, Alvin C. York Campus at 615-225-5491, or via mail addressed to TVHS, ATTN: Release of Information (136H), 3400 Lebanon Road, Murfreesboro, TN 37129. Faxed information that is confirmed as received can be shredded.

Records Retention: The Contractor must retain records generated in the course of services provided under this contract for the time periods required by VHA Record Control Schedule 10-1 and VA regulations (24 VA 136, *Patient Medical Records - VA*, par. *Retention and Disposal*). No hard copies of medical records or logbooks of any type may be maintained. If this agreement is terminated for any reason, the contractor shall promptly provide the VA with any individually-identified VA patient treatment records or information in its possession, as well as the database created pursuant to this agreement, within two (2) weeks of termination date.

4.4.34. WORK RELATED INCIDENT TREATMENT

When treating the veteran for injuries sustained as a result of a work-related incident or an accident, the Contractor must complete the appropriate forms to allow the VA to assert a Federal Medical Care Recovery Act (FMCRA) or a Workers Compensation Claim.

4.4.35. PATIENT RIGHTS, SAFETY, COMPLAINTS, GRIEVANCE SYSTEM PROCESSES

Patient Rights and Responsibilities: Contractor shall conform to all patients' rights issues addressed in VA Medical Center Memorandum (MCM 626-15-00PS-02), Patient/Resident Rights and Responsibilities can be found electronically at http://www.va.gov/health/rights/patientrights.asp.

Safety: Adverse events at the Contractor's site shall be reported to the VA CBOC Manager and the Patient Safety Manager and entered into the Patient Safety Reporting System, as outlined in the National Center for Patient Safety Handbook (http://www.va.gov/ncps/Pubs/NCPShb.doc). Adverse events will be scored utilizing the Safety Assessment Code for determination of the need for conducting a Root Cause Analysis (RCA). Report adverse events to Lead Patient Safety Manager at 615-873-7369 or 615-225-2532. Adverse drug reactions, allergies, and adverse drug events should be appropriately and promptly entered into CPRS.

Patient Complaints: The VA Patient Advocacy Program was established to ensure that all veterans and their families, who are served in VHA facilities and clinics, have their complaints addressed in a convenient and timely manner in accordance with VHA Handbook 1003.4, "VHA Patient Advocacy Program," dated 9/2/05 available at the following hyperlink: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1303.

All patient complaints are reported immediately (within 24 hours.) The CO shall resolve complaints received from the COR concerning Contractor relations with the Government employees or patients. Providers and staff are familiarized with the process outlined in contractor's grievance procedures as well as patient rights. The CO is final authority on validating complaints. In the event that the Contractor is involved and named in a validated patient complaint, the Government reserves the right to refuse acceptance of the services of such personnel. This does not preclude refusal in the event of incidents involving physical or verbal abuse.

Response to complaints will occur as soon as possible, but no longer than seven (7) days after the complaint is made. All patient complaints will be entered in the National Patient Complaint database. Information concerning the Patient Advocacy Program must be prominent and available to patients seen at the Outpatient Site of Care. The VA will provide the Contractor with informational handouts describing the program and how to contact the VA Patient Advocate.

THE GOVERNMENT RESERVES THE RIGHT TO REFUSE ACCEPTANCE of Contractor, if personal or professional conduct jeopardizes patient care or interferes with the regular and ordinary operation of the facility. Breaches of conduct include intoxication or debilitation resulting from drug use, theft, patient abuse, dereliction or negligence in performing directed tasks, or other conduct resulting in formal complaints by patient or other staff

members to designated Government representatives. Standards for conduct shall mirror those prescribed by current federal personnel regulations. The CO and COR shall deal with issues raised concerning contract personnel's conduct. The final arbiter on questions of acceptability is the CO.

Grievance System Requirements: The enrolled patients have the right to grieve actions taken by the Contractor, including disenrollment recommendations, directly to the Contractor. The Contractor shall provide readable materials reviewed and approved by VA, informing enrolled patients of their grievance rights. The Contractor shall develop internal grievance procedures and obtain VA approval of the procedures prior to implementation. The grievance procedures shall be governed by the guidelines in VHA Handbook 1003.4 (dated September 2, 2005).

4.5.36. SPACE REQUIREMENTS: Space standards to meet PACT model are found at http://www.cfm.va.gov/til/dGuide/dgPACT.pdf The Accessibility design standards are defined in the following guide: http://www.cfm.va.gov/til/dGuide/dgBarrFree.pdf

The Contractor's facility must be in compliance with National Fire Protection Association (NFPA) Life/Safety requirements and the Americans with Disabilities Act. VA shall inspect the Contractor's facility before contract start date and retains a rite of inspection throughout the period of performance during normal business hours of 8:00 AM – 4:30 PM, Monday through Friday . Contractor must be in compliance with these requirements prior to contract start date. A list of any deficiencies identified during an inspection will be provided to the Contractor along with a required date for correction of the deficiencies. Any planned changes in the physical environment at the Outpatient Site of Care must be reviewed and approved by the VA to ensure that all life safety codes are met. Parking should be adequate enough to accommodate veteran patients, and shall include at least two (2) handicapped parking spaces.	
(include one per major corridor or ward) Size:40 SF (4x10) **Description: Communications/Technology Closet** **Purpose/Details/Requirements:** 1. Air Conditioned 2. Fire Suppression 3. Solid Core Door 4. Emergency / backup power provided if available 5. No windows, outside / open vents or other gaps **6.** Double locked and keyed separately with copy of key provided to the VA Office of Information & Technology department and the site manager. **7.** Access to this space shall be strictly controlled to ensure adequate information security.	The Contractor shall provide a secure, double locked communications closet to house the computer networking equipment and network patch panel to service the clinic space. Other equipment required by Occupational Safety and Health Administration (OSHA) and TJC.
Description: Equipment and Storage Closet	
Privacy Standards: Veterans must be provided adequate visual and auditory privacy at check-in. Patient names are not posted or called out loudly in hallways or clinic areas. Veterans must be provided adequate visual and auditory privacy in the interview area. Patient-identified information must not be visible in the hall including charts where names are visible. Every effort should be made to restrict unnecessary access to hallways by patients and staff who do not work in that clinic area. Patient dignity and privacy must be maintained at all times during the course of a physical examination. All examination rooms, procedure and testing areas are to have door locks, either electronic or manual. All locks must be safety designed to allow exit from locked rooms without a key or code. Privacy curtains shall be present in all examination, procedure and testing areas with sufficient room so patients can undress behind them. Exam tables are to be placed with the foot facing away from the door and shielded from view by the privacy curtain when the door is opened. Draping techniques shall be used to shield intimate body parts during exams/procedures. Staff should knock and wait to be invited to enter when exam room doors are closed. Gowned patients should have access to sex-specific restrooms without entering public areas. If toilet facilities cannot be located in close proximity to the examination room, the woman must be discreetly offered the sue of a toilet before she disrobes for the exam. **What about space requirements for Connected Care Telehealth for S&F programs such as teleretinal, telederm, and cvt face to face for individual and grpoup classes?**	

4.5.37. EQUIPMENT, OFFICE SUPPLIES AND TECHNICAL SUPPORT: In accordance with VA and VHA directives, policies, and handbooks, all equipment attaching to a VA network will be owned by the VA and controlled by the VA. No other equipment will be connected to this network. The use of the equipment will be for the benefit of the Government in providing care to our veterans. The equipment will only be used by those expressly authorized in support of the VA TVHS Cookeville CBOC or Roane County CBOC. All users must comply with and adhere to VA Directives and VA Cyber Security policies.

Equipment, Office Supplies and/or Support	Contractor	VA
Will be responsible for the PC workstations, software, primary telecommunications lines and networking equipment required to access the VISTA system		**[X]**
Will be responsible for antivirus software for PC workstations and ensure that data definition files are current. In addition the VA will ensure that all Microsoft critical updates and patches are current.		**[X]**
Shall be responsible for the installation and maintenance of the network infrastructure within the facility including, but not limited to, cabling located inside the walls of the structure and a secure communications closet space to house the patch panels and networking equipment	**[X]**	
Shall be responsible for backup, contingency and continuity of operations, the Contractor shall provide connectivity to the Internet via cable modem, DSL or T1 circuits to the communications closet space.	**[X]**	
Will be responsible for connection and management from that Contractor's connectivity to the Internet via cable modem, DSL or T1 circuits to the VA owned networking equipment in the closet.		**[X]**
Will be responsible for backup, contingency, COOP connectivity to the VA and will be established through a VA provided Site-to-Site VPN connection utilizing Contractor provided Internet Service Provider (ISP).		[X]
Will be responsible to provide and manage the necessary VPN security router hardware.		[X]
Shall be responsible for maintenance and on-going technical support for all data and voice wiring within the walls and ceilings from the data closet to the endpoints of the network.	[X]	
Shall be responsible for all charges related to the backup, contingency, and COOP connectivity.	[X]	
Shall be responsible for procurement, installation and maintenance of all printers, copiers, scanners, fax machines*, shredders, or other peripheral office equipment and all related and ongoing supplies (paper, toner, ink cartridges) required to operate the equipment in support of the facility under the specifications of this contract. * VA Handbook 6500 that requires the following statement on all fax cover sheets be included: *This fax is intended only for the use of the person or office to which it is addressed and may contain information that is privileged, confidential, or protected by law. All others are hereby notified that the receipt of this fax does not waive any applicable privilege or exemption for disclosure and that any dissemination, distribution, or copying of this communication is prohibited. if you have received this fax in error, please notify this office immediately at the telephone number listed above."*	[X]	

Shall be responsible for all office supplies (pens, paper, pencils, folders, paper clips and other supplies to facilitate operation of the clinic.	[X]	
Shall be responsible for all clinical supplies to accomplish all required work in this contract, other than those provided by the VA specifically mentioned in this document. **What about telehealth supplies**	[X]	
Shall be Responsible for ensuring hardware/software compatibility with VA approved list: The following printers have passed compatibility testing with the VISTA Encounter Form: Lexmark T642n, Lexmark T644n and Lexmark E342n or compatible. The Contractor shall also provide one small desktop color printer for printing patient education information. The following scanner has passed compatibility testing with the VISTA Imaging System: Fujitsu fiI-4340C Sheet Feed Scanner (Any other model used will require approval and certification for Vista Imaging)	[X]	
Will be responsible to provide advisory technical support to the Contractor's technical support person for the initial site set-up relative to VISTA, CPRS and VPN connectivity. The VA will provide on-going technical support for VISTA and CPRS software and any other VA software applications. Technical support will be through an escalation process. The Contractor's employee technical representative will submit a "Help Desk" request by calling 615-225-6500. Initial technical support will be provided by the VA via telephone, which will consist of a VA technical representative speaking to a Contractor employed representative to identify the problem, trouble-shoot and attempt to resolve the problem with the Contractor's end-user. If the problem cannot be resolved the VA will provide on-site support for VA owned equipment, VISTA, CPRS software and other VA software applications, if necessary within two business days or less depending on the nature and severity of the problem.		[X]
Shall be responsible for having a contingency plan for computer downtime that defines the processes in order to ensure continuity of patient care and maintenance of the integrity of the patient's medical record during periods of loss of computer functions. The contingency plan must be reviewed and approved by the Contracting Officer prior to award. In addition, a contingency plan template that designates criticality of application/system, estimate of impact, locations of equipment, and contact persons will be provided to the Contractor for completion after award.	[X]	
Shall be responsible to supply sanitary napkin and tampon dispensers and dispoal bins in women's public restrooms. Tampons and sanitary pads should also be available in examination rooms where pelvic exams are performed and in bathrooms within close proximity.	[X]	
Shall provide diaper changing stations in designated male and female or unisex restrooms.	[X]	

4.6. **PERFORMANCE STANDARDS, QUALITY ASSURANCE AND QUALITY IMPROVEMENT**: Services and documentation of care provided under the resultant contract shall be subject to quality management and safety standards as established by VA, consistent with the standards published by TJC or equivalent. The contractor shall develop and maintain Quality Improvement/ Quality Assurance Programs and provision of care equal to or exceeding VA Standards. The results of all Quality Improvement activities performed by the contractor involving VA patients will be shared with VA Quality Management Office. Documentation by the Contractor provided to the VA includes, but is not be limited to the following:

4.6.1. Quality improvement plans: Staff meetings minutes (or summary minutes) where quality improvement has been discussed and which include practitioner-specific findings, conclusions, recommendations and written plans for actions taken in response to such conclusion and recommendations, and evaluation of those actions taken.

4.6.2. Contractor must be accredited by TJC or maintain a level of service that is in compliance with all current TJC standards. If the Contractor is TJC accredited, he/she will be required to furnish a copy of the accreditation letter(s) upon request by the Contracting Officer prior to award.

4.6.3. The Contractor shall notify the Chief of Staff in writing whenever a malpractice claim involving a VA patient has been filed against the Contractor. The Contractor shall forward a copy of the malpractice claim within three (3) workdays after receiving notification that a claim has been filed. The Contractor shall also notify the VA Special Assistant to the Chief of Staff when any provider furnishing services under this contract is reported to the National Practitioner Data Bank. This notification will include the name, title, and specialty of the provider. All written notifications shall be sent to the following address: VA Tennessee Valley Healthcare System, Office of Chief of Staff (11), 1310 24th Ave. South, Nashville, TN 37212. The Chief of Staff or designee will notify the CO of any notifications received from the Contractor.

4.6.4. The Contractor shall permit on-site visits by VA personnel and TJC surveyors accompanied by VA personnel and/or other accrediting agencies to assess contracted services, e.g., adequacy, compliance with contract requirements, record-keeping, etc.

4.6.5. The Contractor is responsible for the quality management plan for monthly clinical pertinence review of ambulatory care records. The results shall be forwarded to the Chair of the Medical Records Committee via the Health Information Management Service (HIMS). If in the course of VA business, a concern is identified, the issues must be addressed by the Contractor and a performance improvement plan initiated. Recommendations and implementation of performance improvement activities will be the responsibility of the Program Director of the clinic.

4.6.6. The VA is committed to providing high quality primary care. The VA measures quality in primary care through its performance measurement system. Several "process" and "outcome" measures are extracted by external reviewers from random samples of records of veterans who visited VA primary care providers at the Contractor's Outpatient Site of Care. These measures change from year to year. The current performance measures and method of extraction are available at http://vaww.oqp.med.va.gov. The Contractor is responsible for achieving levels of performance on these measures that meet or exceed the annual expectations as outlined in the Network Performance Plan and Network Technical Manual. Revisions/updates to the Network Performance Plan and Network Technical Manual may be obtained from the above website. The Contractor is required to utilize the VISTA CPRS clinical reminder system as a means of both ensuring high performance on these measures and to facilitate monitoring of performance at the site independent of external reviewers. Levels of performance on the quality measures in primary care will be used as a factor in decisions about renewal of the contract.

4.6.7. The Contractor shall document in writing on appropriate orientation programs for all employees involved in the delivery of patient care, e.g., infection control procedures, patient confidentiality, handling emergencies, patient safety, etc., and provide a copy to the VA COR. Contractor shall be required to furnish method/guidelines by which he/she intends to meet above requirement.

4.6.8. The Contractor shall have a quality monitoring/performance improvement program. This program shall be available to VA staff and JC. The VA will provide regular feedback on clinic performance measures, including but not limited to the following: licensure verification, workload, consults, drug and lab utilization, formulary compliance, prescription writing patterns, Prevention and Performance measures, patient satisfaction, and medical record completeness. The Contractor shall conduct audits pertaining to access, quality improvement, documentation, safety and performance measures. These reports shall be submitted to the COR on a monthly basis and sent via secured email using PKI or utilizing UPS.

4.6.9. The Contractor shall comply with all PBM formulary guidance regarding medication use, monitoring and safety.

4.6.10. The Contractor shall collaborate with VA Pharmacy when patients are identified that require intervention.

4.6.11. The Contractor shall meet all Federal, State, and Local fire and Life Safety Codes.

4.6.12. The Contractor shall be responsible for meeting national quality standards and shall comply with mandated policies established by VA Central Office (VACO) Patient Care Services (PCS). Each fiscal year new quality standards are developed by PCS and forwarded to each VISN for implementing at each primary care site. Those standards are found at the VA website and also provided by the COR for implementing.

4.7. PERFORMANCE STANDARDS AND SURVEILLANCE

4.7.1. MEASURE: CLINICAL REMINDERS

Performance Requirement: VISTA/CPRS will automatically remind providers to complete the following clinical reminders during patients visits:
-Alcohol Use Screen
-Positive AUDIT-C Needs Evaluation
-Depression Screening
-Evaluation of positive PTSD
-Tobacco Counseling by provider FY XX
-Tobacco Counseling by provider (medication offering)
-Tobacco Counseling FY XX
-Iraq and Afghanistan Post- Deployment Screening
-TBI Screening
-Influenza Immunization
-Pneumovax
-Colorectal Ca Screening
-FOBT Positive F/U
-Diabetes Eye Exam
-Diabetes Foot Exam
-Mammogram Screening (must document month, year, results and former provider if outside VA)
-Pap Smear Screening (must document month, year, results and former provider if outside VA)

Standard: 100% Proper documentation and completion of all clinical reminders as they appear during a patient's visit
Acceptable Quality Level: 92% completion of clinical reminders each month.
Surveillance Method: VA will monitor progress weekly using data from VA VISTA/CPRS.
Frequency: VA will send these weekly reports to the contractor to notify them to their current performance.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures shall result in the following deductions:

87%-91.9%: A disincentive equaling 5% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance rating of Marginal may be assigned

82%-86.9%: A disincentive equaling 10% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.
81.9% and below: A disincentive equaling 10% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.

4.7.2. MEASURE: NEW PC PATIENT WAIT TIME (PC 14)

Performance Requirement: All patients requesting an appointment for any clinic must receive an appointment in a timely manner.
Standard: The Contractor shall schedule routine new patient appointments within thirty (30) calendar days of Primary Care request by patient.
Acceptable Quality Level: 99.7% monthly; New PC appointments completed no later than 30 calender days of patient request.
Surveillance Method: VHA SAIL Report http://reports2.vssc.med.va.gov/reportserver?%2fMgmtReports%2fVATR%2fSAIL_Prod%2fSAIL&rs:Command=Render, Periodic Sampling VA will monitor using Electronic report using data from VA VISTA/CPRS system.
Frequency: Monthly; VA will monitor using VHA SAIL Report , electronic report using data from VISTA/CPRS. Contractor can check status of their performance by running reports in VISTA/CPRS as frequently as needed.
Incentive: Satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures shall result in the following deductions:

95%-99.6%: A disincentive equaling 10% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal may be assigned.
89%-94.9%: A disincentive equaling 15% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.

4.7.3. MEASURE: ESTABLISHED PC PATIENT WAIT TIME (PC12)

Performance Requirement: Established PC patient Prospective Wait Times using desired date completed within thirty (30) calendar days of requested date.
Standard: Established PC Patient primary care appointments completed within thirty (30) calendar days of requested date.
Acceptable Quality Level: 94% monthly; established PC appointments completed no later than 30 calendar days of requested date.
Surveillance Method: VHA SAIL Report http://reports2.vssc.med.va.gov/reportserver?%2fMgmtReports%2fVATR%2fSAIL_Prod%2fSAIL&rs:Command=Render, Periodic Sampling VA will monitor using Electronic report using data from VA VISTA/CPRS system.
Frequency: VA will monitor and report progress Quarterly (non-cumulative) Monthly; VA will monitor using VHA SAIL Report , electronic report using data from VISTA/CPRS. Contractor can check status of their performance by running reports in VISTA/CPRS as frequently as needed.
Incentive: Satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in the following deductions:

95%-99.6%: A disincentive equaling 10% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal may be assigned.
89%-94.9%: A disincentive equaling 15% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.

4.7.4. MEASURE: SAME DAY APPOINTMENTS WITH PRIMARY CARE PROVIDER (PCP) [PACT 7]

Performance Requirement: Same day appointments provided with PCP
Standard: 70% completion of same day primary care appointments with PCP
Acceptable Quality Level: 48% completion of same day primary care appointments with PCP

Surveillance Method: Periodic Inspection audit of VHA Performance Measure Report and PACT Compass
Frequency: VA will monitor and report progress Quarterly (non-cumulative)
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in the following deductions:

≤47.9%: A disincentive equaling 5% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal may be assigned.

4.7.5. MEASURE: CLINICAL ENCOUNTERS

Performance Requirement: Providers must complete proper documentation for each patient visit.
Standard: 100% Documentation must be complete for all fields including whether or not the patient is service connected. The CPT and provider codes must match and codes must accurately reflect complexity of visit. Complete documentation must be completed before the 18th of each month.
Acceptable Quality Level: 99.9% completion of clinical encounters each month.
Surveillance Method: Random Sampling (auditing) VA will monitor using Electronic report using data from VA VISTA/CPRS system.
Frequency: VA will monitor progress weekly thru automated reports. VA will send these weekly reports to the contractor to notify them to their current performance.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures shall result in the following deductions:

90%-99.9%: A disincentive equaling 5% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance Rating of Marginal may be assigned.
80%-89.9%: A disincentive equaling 10% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.
79.9% and below: A disincentive equaling 15% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.

4.7.6. MEASURE: PHARMACY

Performance Requirement: Contractor shall submit a non-formulary and restricted drug request in CPRS using the PBM consult option. . Contractor will be evaluated on acceptable quality level depicted below.
Standard: 100% (zero disapproval ratings for non-formulary and restricted drug requests quarterly).
Acceptable Quality Level: 90% (no more than 10% disapproval ratings for non-formulary and restricted drug requests quarterly).
Surveillance Method: Periodic Sampling VA will monitor using Electronic report using data from VA VISTA/CPRS system.
Frequency: VA will monitor progress monthly thru automated reports. VA will send these monthly status reports to the contractor to notify them to their current performance.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures shall result in the following deductions: 89.9% (more than 10% disapproval ratings for non-formulary and restricted drug requests quarterly). A disincentive equaling 10% of the quarter's PC invoices when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned. How do we impose a disincentive for PC invoices that have been certified and paid in previous months?

4.7.7. MEASURE: PHARMACY NEW DRUG ORDER REQUESTS

Performance Requirement: Contractor shall submit new drug orders through CPRS to VA.
Standard: 100% The contractor shall ensure that all new drug order requests follow all VA prescribing guidelines. This is including but not limited to ensuring all appropriate labs have been previously ordered and that the order is not a non-formulary drug
Acceptable Quality Level: 95% of new drug order requests follow all VA prescribing guidelines. This is including but not limited to ensuring all appropriate labs have been previously ordered and that the order is not a non-formulary drug

Surveillance Method: Periodic Sampling. The VA will monitor using Electronic report using data from VA VISTA/CPRS system.
Frequency: VA will monitor progress quarterly thru automated reports. VA will send monthly status reports to the contractor to notify them to their current performance.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures shall result in the following deductions: 94.9% or less of new drug order requests follow VA prescribing guidelines. A disincentive equaling 10% of the quarter's PC invoices when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned. How do we impose a disincentive for PC invoices that have been certified and paid in previous months?

4.7.8. MEASURE: VESTED PATIENTS (IS THIS REALLY OF VALUE? RECOMMEND DELETE)
Performance Requirement: Contractor shall maintain a specific number of vested patients in the clinic. Standard: Contractor to maintain _____ active vested patients in the clinic for at least three of the option years.
Acceptable Quality Level: 90% of required active vested patients in the clinic for at least three of the option years.
Surveillance Method: VA will monitor using Electronic report using data from VISTA/CPRS annually. Contractor can check the status of their performance by running reports in VISTA/CPRS as frequently as needed.
Frequency: VA will monitor progress annually thru automated reports.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.7.9. MEASURE: PACT PATIENTS ENROLLED IN HOME TELEHEALTH (HT) [PACT 13]
Performance Requirement: Contractor shall maintain a specific number of vested patients enrolled in HT.
Standard: Contractor to maintain 1.6% of required vested patients in HT.
Acceptable Quality Level: 1.2% of required vested patients enrolled in HT
Surveillance Method: VA will monitor using Electronic report using data from Performance Measure Report: T21, Quality and PACT Dashboard.
Frequency: VA will monitor progress quarterly (non-cumulative) thru automated reports.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.7.10. MEASURE: PRIMARY CARE PATIENTS IN MENTAL HEALTH INTEGRATION (PCMHI) [PACT 15]
Performance Requirement: Contractor reports PCMHI Penetration that uses patients assigned to a PACT team as the cohort (instead of core uniques with a primary care encounter). *The percent of assigned primary care patients seen in a primary care mental health integration (PCMHI) clinic (primary stop code 534 or 539) or by a HBPC mental health provider (primary stop code 156 and 157) or when primary stop code is either 338 or 527 and secondary stop code is 534. Only required divisions are included in this measure which consist of large (5,000 or more core uniques) and very large (10,000 or more core uniques) divisions. Core uniques include all patients except those whose interaction with the facility is limited only to laboratory and telephone triage episodes of care.* ***Numerator for Primary Care Patients in PCMHI*** *– The total number of assigned primary care patients seen in primary care mental health integration (PCMHI) during the past 12 months.* ***Denominator for Primary Care Patients in PCMHI*** *– The total number of primary care patients assigned to a primary care provider on the last day of the month.*
Standard: Contractor to maintain 6% of required vested patients in PCMHI.
Acceptable Quality Level: Contractor to maintain 4% of required vested patients in PCMHI.
Surveillance Method: VA will monitor using Electronic report using data from Performance Measure
Report: T21, Quality and PACT Dashboard.
Frequency: VA will monitor progress quarterly (non-cumulative) thru automated reports.
Incentive: satisfactory or better past performance

Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.7.11. MEASURE: RATIO OF NON-TRADITIONAL ENCOUNTERS [PACT 16]

Performance Requirement: Contractor reports the sum of all PC Telephone encounters added to the sum of all PC Group Encounters added to the sum of all incoming and outgoing secure messages as the numerator.
Standard: Contractor shall maintain at least 20% in the appropriate ratio of non-traditional encounters.
Acceptable Quality Level: Contractor shall maintain at least 12% in the appropriate ratio of non-traditional encounters.
Surveillance Method: VA will monitor using Electronic report using data from Performance Measure Report: T21, Quality and PACT Dashboard.
Frequency: VA will monitor progress quarterly (non-cumulative) thru automated reports.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.7.12. MEASURE: POST DISCHARGE CONTACT BY PACT TEAM [PACT 17]

Performance Requirement: Number of discharges with follow-up contact by a member of the assigned PACT Team within two business days of discharge. Standard: Contractor assigned PACT Team member shall contact at least 75% of patients within two business days of discharge.
Acceptable Quality Level: Contractor assigned PACT Team member shall contact at least 40% of patients within two business days of discharge.
Surveillance Method: VA will monitor using Electronic report using data from Performance Measure Report: T21, Quality and PACT Dashboard.
Frequency: VA will monitor progress quarterly (non-cumulative) thru automated reports.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.7.13. MEASURE: PACT STAFFING RATIO [PACT 18] - This is the critical measure for ensuring care requirements at each CBOC. If the clinic PACTs are staffed appropriately, then the majority of other QASP measures should be achieved.

Performance Requirement: Percent of CBOC Meeting PACT Staffing Ratio of 3:1 (RN, LPN and MSA : PCP) on a monthly basis.
Standard: CBOC shall meet PACT Staffing Ratio of 3:1 at least 95% of the time on a monthly basis.
Acceptable Quality Level: CBOC shall meet PACT Staffing Ratio of 3:1 at least 95% of the time.
Surveillance Method: VA will monitor using Electronic report using data from Performance Measure Report: T21, Quality and PACT Dashboard.
Frequency: VA will monitor progress monthly (non-cumulative) thru automated reports.
Incentive: Satisfactory or better past performance
Disincentive:

90%-94.9%: A disincentive equaling 10% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal may be assigned.
85%-89.9%: A disincentive equaling 15% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.
85% and below: A disincentive equaling 25% of that month's PC invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.
Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.7.14. MEASURE: PATIENT SATISFACTION WITH ACCESS MEASURE COMPOSITE [PCMH 4; SHEP]

Performance Requirement: Composite % Based on 2 Questions: Get an urgent care appointment as soon as needed,Get a routine care appointment as soon as needed
Standard: At least 55%

Acceptable Quality Level: 53.8%
Surveillance Method: VHA SAIL Report or Patient Experience Report
Frequency: VA will monitor progress quarterly (non-cumulative) thru automated reports.
Incentive: Satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.7.15. MEASURE: APPOINTMENT CANCELLATIONS

Performance Requirement: Contractor shall not unnecessarily cancel patient appointments and will reschedule cancelled appointments in a timely manner. Any appointment cancelled needs to be rescheduled within 2 weeks. This means the patients must be seen within 2 weeks of the original cancelled appointment date.
Standard: 100% of patients seen within 2 weeks of the original cancelled appointment date.
Acceptable Quality Level: 100% of patients seen within 2 weeks of the original cancelled appointment date
Surveillance Method: Periodic Sampling VA will monitor using Electronic report using data from VA VISTA/CPRS system.
Frequency: VA will monitor progress through quarterly audits using automated reports. Contractor can check the status of their performance by running reports in VISTA/CPRS system.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures shall result in the following deductions:

95%- 99.9%: A disincentive equaling 10% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance Rating of Marginal or Unsatisfactory may be assigned.

90%-94.9%: A disincentive equaling 15% of that month's (PC and/or MH, as applicable) invoice when the AQL was not met. Past Performance Rating of Unsatisfactory may be assigned.

4.7.16. MEASURE: PRIMARY CARE PROVIDER CONTINUITY (PACT 8)

Performance Requirement: Patients see same PCP for appointments
Standard: 77% of appointments provided with assigned PCP
Acceptable Quality Level: 65% of appointments provided with assigned PCP
Surveillance Method: VA will monitor using Electronic report using data from Performance Measure Report: T21, Quality and PACT Dashboard.
Frequency: VA will monitor progress quarterly (non-cumulative) thru automated reports.
Incentive: satisfactory or better past performance
Disincentive: Negative Past Performance, Failure to meet VA performance measures may result in marginal or unsatisfactory past performance rating.

4.8. REQUIRED REGISTRATION WITH CONTRACTOR PERFORMANCE ASSESSMENT REPORTING SYSTEM (CPARS)

4.8.1. As prescribed in Federal Acquisition Regulation (FAR) Part 42.15, the Department of Veterans Affairs (VA) evaluates Contractor past performance on all contracts that exceed $150,000, and shares those evaluations with other Federal Government contract specialists and procurement officials. The FAR requires that the Contractor be provided an opportunity to comment on past performance evaluations prior to each report closing. To fulfill this requirement VA uses an online database, CPARS, which is maintained by the Naval Seal Logistics Center in Portsmouth, New Hampshire. CPARS has connectivity with the Past Performance Information Retrieval System (PPIRS) database, which is available to all Federal agencies. PPIRS is the system used to collect and retrieve performance assessment reports used in source selection determinations and completed CPARS report cards transferred to PPIRS. CPARS also includes access to the federal awardee performance and integrity information system (FAPIIS). FAPIIS is a web-enabled application accessed via CPARS for Contractor responsibility determination information.

4.8.2. Each Contractor whose contract award is estimated to exceed $150,000 is required to register with CPARS database at the following web address: www.cpars.csd.disa.mil. Help in registering can be obtained by contacting Customer Support Desk @ DSN: 684-1690 or COMM: 207-438-1690. Registration should

occur no later than thirty days after contract award, and must be kept current should there be any change to the Contractor's registered representative.

4.8.3. For contracts with a period of one year or less, the contracting officer will perform a single evaluation when the contract is complete. For contracts exceeding one year, the contracting officer will evaluate the Contractor's performance annually. Interim reports will be filed each year until the last year of the contract, when the final report will be completed. The report shall be assigned in CPARS to the Contractor's designated representative for comment. The Contractor representative will have thirty days to submit any comments and re-assign the report to the VA contracting officer.

4.8.4. Failure to have a current registration with the CPARS database, or to re-assign the report to the VA contracting officer within those thirty days, will result in the Government's evaluation being placed on file in the database with a statement that the Contractor failed to respond.

5. GOVERNMENT RESPONSIBILITIES:

5.1. Oversight of Service/Performance Monitoring:

5.1.1. **CO Responsibilities:** The CO is the only person authorized to approve changes or modify any of the requirements of this contract. The Contractor shall communicate with the CO on all matters pertaining to contract administration. Only the CO is authorized to make commitments or issue any modification to include (but not limited to) terms affecting price, quantity or quality of performance of this contract. The CO shall resolve complaints concerning Contractor's provider relations with the Government employees or patients. The CO is final authority on validating complaints. In the event the Contractor effects any such change at the direction of any person other than the CO without authority, no adjustment shall be made in the contract price to cover an increase in costs incurred as a result thereof. In the event that contracted services do not meet quality and/or safety expectations, the best remedy will be implemented, to include but not limited to a targeted and time limited performance improvement plan; increased monitoring of the contracted services; consultation or training for the contract staff to be provided by the VA; replacement of the contract staff and/or renegotiation of the contract terms or termination of the contract.

5.1.2. The COR: The COR shall be the VA official responsible for verifying contract compliance. After contract award, any incidents of Contractor or Contractor's provider noncompliance as evidenced by the monitoring procedures shall be forwarded immediately to the Contracting Officer. The COR will be responsible for monitoring the Contractor staff performance to ensure all specifications and requirements are fulfilled. Quality Improvement data that will be collected for ongoing monitoring is outlined in the QASP. The COR will maintain a record-keeping system of services by reviewing the QASP and invoices submitted by the Contractor. The COR will review this data monthly when invoices are received and certify all invoices for payment. Any evidence of the Contractor's non-compliance shall be forwarded immediately to the Contracting Officer. The COR will review and certify monthly invoices for payment. If in the event the Contractor fails to provide the services in this contract, payments will be adjusted to compensate the Government for the difference.

5.1.3. Contract Administration: All contract administration functions will be retained by the VA. After award of contract, all inquires and correspondence relative to the administration of the contract shall be addressed to: Contracting Officer (CO): Carol Franklin, 615-225-6972, Carol.Franklin@va.gov

The Contracting Officer's Representative (COR) for this contract is:

David W. Webb, 615-225-3888, david.webb10@va.gov

Department of Veterans Affairs
Tennessee Valley Healthcare System
Mail Stop: 11CBOC (Attn: David Webb)
3400 Lebanon Pike

Liaison Persons: While the liaison persons identified and other VA staff may be contacted for questions/information and/or may visit the Contractor's sites to oversee policy compliance, **only the CO is authorized to make commitments or issue changes which will affect the price, quantity, quality, or delivery terms of this contract.** Any guidance provided, which the Contractor feels is beyond the scope of this contract, must be communicated to the CO, via the COR, for possible contract modification. The VA has designated the following liaison personnel for this resultant contract:

Title	Role	Phone Number
Chief, CBOC Service	Clinical Contact	615-225-3888
Chief Nurse, PC/CBOCs	Clinical Contact	615-225-2969
Mental Health Coordinator	Clinical Contact	615-225-3638
Administrative Officer of the Day	Contact for any administrative and clinical problems that arise after normal working hours of 8:00 AM-4:30 P.M., Monday - Friday, weekends and holidays	615-225-4714 or 615-225-4715 or 615-225-4716
IRM "Help Desk"	Assistance with VISTA	615-225-6500
Patient Registration Office	Assistance with Patient Eligibility	615-873-8422
Medical Care Cost Recovery	Assistance with Financial Assessments	1-888-313-5421
Outpatient Pharmacy	Outpatient Pharmacy Supervisor	615-225-2973 or 615-873-7670
Health Information Management Service	Assistance with CPRS and Medical Records	615-225-3452 or 615-873-7420
VA Patient Advocate	Assistance with patient complaints, etc.	615-873-7932
Ancillary Testing	Questions involving lab work, x-rays, and other ancillary testing	615-225-6599 or 615-225-5545
Pathology and Laboratory Medicine	Chief Medical Technologist for pathology and laboratory medicine	615-873-7015
Women Veterans Health Services	~~Program Manager for women veterans health issues~~ Women Veterans Program Manager for administrative/policy questions Women's Health Medical Director for clinical questions Maternity Care Coordinator	615-327-4751 x63020 615-327-4751 x63020 615-225-5535
Radiology Service	Chief Technologist for radiology imaging related questions	615-225-3833 or 615-873-7934

5.1.4. The Contractor shall identify a contact person(s), who shall serve as liaison between the Contractor and the VA. This individual will also ensure the functionality of the clinic according to contract specifications. The contact person(s) will be available during the administrative tour of duty from 8:00 AM - 4:30 PM Monday through Friday. The Contractor's point of contact for other than its normal working hours should be reachable by phoning the 24-hour Phone Triage number referenced in paragraph Patient Scheduling.

6. SPECIAL CONTRACT REQUIREMENTS

6.1. CONTRACT START-UP REQUIREMENTS:

6.1.1. The Contractor's start-up requirements must be completed prior to the commencement of the Contractor's treatment of VA enrolled patients. Upon approval by the VA of the Contractor's completion of the start-up requirements, the VA will issue a written Notice to Proceed to the Contractor.

6.1.2. The Contractor shall have ninety (90) days from contract award to commencement of the provision of medical care to local veterans. However, the Contractor must have all start-up requirements in place and ready to commence operation NLT eighty-three (83) calendar days from contract award. The final seven (7) days will be used for training and resolution of any last minute or unexpected technical or personnel related challenges. The Contractor shall comply with the following contract requirements prior to commencement of clinical operations:

6.1.2.1. The Contractor shall hire, train, and ensure licensure of all necessary personnel.

6.1.2.2. The Contractor shall furnish evidence of insurability of the offeror and/or of all health-care providers, who will perform under this contract (see VAAR 852.237-7, Indemnification and Medical Liability Insurance, OCT l996).

6.1.2.3. All Contractor-provided health care services shall be available.

6.1.2.4. The Contractor's case management program with primary care providers as case managers for all health care services provided to enrolled patients shall be operational.

6.1.2.5. The Contractor's VA approved performance improvement program shall be operational.

6.1.2.6. The Contractor's facility shall be in compliance with the requirements of this contract.

6.1.3. The VA will provide training to the Contractor at the VA main campus site(s) relative to data reporting needs, computer system access to VISTA, CPRS, eligibility issues, billing procedures and medical referral procedures within eighty-nine (89) calendar days of contract award. The contractor is responsible for coordination and/or payment of contract staff travel expenses in accordance with General Services Administration (GSA) rates, https://www.gsa.gov/portal/category/100000 during contract start-up. The Contractor is responsible for provision and/or coordination of future staff training after the initial ninety (90) calendar days of contract award (e.g. new requirements, new staff) in accordance with VA policies. requirements. If the Contractor does not have qualified staff to provide required training courses, the Contractor is responsible for coordination and/or travel of contract staff to be trained at VA main campus site(s). The contractor is responsible for coordination and/or payment of contract staff travel expenses in accordance with General Services Administration (GSA) rates, https://www.gsa.gov/portal/category/100000 . The Contractor must provide documentation of training prior to Pathology and Laboratory Medicine providing access to VISTA laboratory software options. The Contractor shall be responsible for attendance and performance regarding training sessions. Training will be coordinated by the COR and the Contractor's designee. After contract performance begins, VA staff is readily available by telephone and e-mail to answer questions and provide guidance.

6.1.4. Upon receipt of Notice of Award, Contractor shall immediately commence the credentialing and privileging process for all physicians and social workers through the VA. A minimum of six (6) calendar weeks is required for VA credentialing after the package has been completed and received from the provider.

6.1.5. Patient Transportation: Each patient will be responsible for his/her own transportation to appointments.

6.1.6. Signage: The Contractor shall furnish and install, after receiving facility approval, clearly visible signage on the exterior of the building, in the front window, or on the door which displays the VA logo and complies with the VA directive regarding Exterior Signs set forth in the Office of Construction & Facilities Management guidebook which can be located at http://www.cfm.va.gov/til/signs/Signage04-Exterior.pdf.

6.1.7. The Contractor shall provide the Contracting Officer with a diagram of the proposed sign which specifies dimensions and identifies the installation location for approval by the Contracting Officer prior to

fabrication of the sign. The VA has renamed Community Based Outpatient Clinics, when necessary, to reflect the county in which they are located. These CBOCs shall be referred to as the VA Clinic Cookeville and VA Clinic Roane County.

6.2. **BILLING-CPT CODES:** The Contractor shall adhere to the most current procedural terminology (CPT) coding standards used for primary care and mental health services – examples listed of CPT and Health Care Common Procedural Coding System (HCPCs) – this list is not all inclusive as it is subject to conformance to the Centers for Medicare and Medicaid Services (CMS) regulations. The contractor shall submit applicable codes should changes be required based on CMS updates. As such, the contractor is responsible for identifying applicable CPT, HCPCs and any additional coding each year as CMS regulations are updated. These codes are for both primary care and MH services – please adjust if your services proposed are, for example, primary care only.

CPT CODES	SERVICES
90801, 90804, 90806, 90808, 90847, 90853	Individual Psychotherapy (Mental Health)
90847, 90847	Group/Family Psychotherapy (Mental Health)
99201-99215	Office or Other Outpatient Services (Primary Care)
99354-99355	Prolonged Services Face to Face
10060, 10061, 10120, 10140, 10160, 10180, 11000, 11001, 11040, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11732, 11740, 11900, 20550, 20600, 20605, J0702, J0704, G0127, 28510	Podiatry Services.
99441-99443	Telephone Calls to Patient or Other Health Care Professionals
99381-99397	Preventive Medicine Service
99401-99429	Counseling and or Risk Factor Reduction Intervention
36410, 36415	Venipuncture for collection of specimens
Included in CPT codes listed elsewhere in this table.	Female: Women's health services, including but not limited to, pelvic/breast exams; contraception counseling and management; management of osteoporosis, menopause, pelvic pain, abnormal uterine bleeding, and sexually transmitted diseases; in addition to screening for breast and cervical cancer or, a history of sexual trauma. Referral for pregnancy, mammography and recognition of ectopic pregnancy. GYN abnormalities should be referred through a Gynecology consult to the Parent facility.
65205	Eye: Superficial removal of foreign bodies.
69000-69200 69210	Ear: Simple procedures (e.g., drainage ext. ear abscess, removal foreign body).
70010TC-76499TC	Diagnostic Radiology and Diagnostic Imaging shall be performed with the exclusion of invasive procedures, Fluoroscopy, MRI, CT, Nuclear Medicine, and Ultrasound. Contract services include technical component only; professional interpretation to be performed by VA. Mammography will be fee based to a certified mammography center in the area.

81002, 81025, 82272QW, 82075, 82948, 83036QW, 85610QW	Laboratory Services as follows: Urinalysis (non-automated w/o microscopic), pregnancy testing (visual color comparison), occult blood feces 1-3 tests, breath alcohol, whole blood glucose, glycated Hemoglobin (A1C), and prothrombin time/INR. Optional Provider Performed Tests are as follows: Gastroccult and crystals. Note: These (waived) laboratory tests can be typically done in physicians' offices. All other laboratory services should be referred to VA.
90700-90749	Immunization Injections as recommended by CDC, or other recognized medical groups/academies.
93000, 93005, 93010, 93040, 93041, 93042	Cardiography Services are limited to ECG performance and interpretation. Note: The Contractor must utilize MUSE-compatible EKGs – FILLIN – VA provided EKGs and Holter Monitor (as applicable to your facility).
94010, 94060, 94640, 94760	Performance and interpretation of spirometry and pulse oximetry for oxygen saturation. Other pulmonary procedures are excluded.
10060, 10061, 10080, 10081, 10120, 11200, 11730, 11770, 12001, 12002, 12004, 12005, 12006	Minor Surgery. Procedures are limited to minor surgeries that only require local anesthesia.

6.2.1. VESTING AND BILLABLE ROSTER:

6.2.1.1. Additions to Billable Roster

Contractor shall maintain a specific number of vested patients in the clinic. All patients associated with contracted clinic should have current and active VESTING CODE visit per VHA Guidelines. List of VERA Vesting CPT codes (Active since 2008) http://vaww.arc.med.va.gov/references/Handbook12/vera_2012_vesting_cpt.xls

6.2.1.1.1. **Vesting Providers:** Only certain clinicians are authorized to Vest patients in the VHA. The list of vesting clinicians includes physicians (residents are physicians), physician assistants, clinical nurse specialists and nurse practitioners. In general, these clinicians are recognized as providers that perform primary care in outpatient settings. The "person class" field in the VHA database identifies the VHA professional, and the precise list of clinician codes is linked below. As many as ten clinical providers can be associated with a single CPT code. However, while the databases will allow other professionals to use the Vesting CPT codes, a patient will not be Vested in the ARC's Patient Classification process unless at least one of the ten clinicians is an authorized provider. Clinical Providers (as of January 1, 2012)

6.2.1.1.2. VA has the sole authority to assign Veterans who are treated by the Contractor into the PCMM software program used to track Primary Care Clinic Veteran rosters/PCP panels. Eligibility determination and enrollment of VA eligible enrolled Veterans in the Contractor's plan shall be the responsibility of the VA. The Contractor is responsible for notifying the VA through electronic shared-drive spreadsheets of newly seen Veterans at the Contractor's site that are not already assigned in the PCMM software program. The VA will then verify that the Veteran was seen through VISTA documentation, and enter the Veteran into the PCMM software as credited to the Contractor's site and associated clinic roster.

6.2.1.1.3. If the Contractor seeks to place a Veteran on the billable roster at the Contractor's site but is already assigned to another primary care team or provider in the VHA, the VA will have final authority to designate the primary care site for the Veteran. The main basis for this decision will be Veteran preference. Veterans shall not be allowed to be assigned to more than one VA Outpatient Site of Care. In addition, Veterans will not be allowed to be assigned simultaneously at the Contractor's site and in any of the primary care teams at the VA. A Veteran's checked out visit to a particular Outpatient Site

of Care shall be deemed to be an expression of that Veteran's preference as to a particular primary care site.

6.2.1.1.4. For Veterans newly assigned in PCMM, the Contractor shall be paid the monthly capitation rate for the full month in which the first visit occurs where medical care is provided to the Veteran at the Contractor's facility by a PCP completing and properly documenting an appropriate vesting visit and using the proper vesting CPT Codes. (Podiatrists, nurses, dieticians, social workers, psychologists, etc., are not considered appropriate PCPs by VA.). Acceptable Vesting CPT Codes for this purpose are: 99203-99205; 99213-99215; 99243-99245; 99385-99387; or 99395-99397. All payments shall be monthly in arrears. MH Vesting CPT Codes are 90791 – 90792 and must be completed in a minimum 45 minute scheduled appointment.

6.2.1.2. Removal from Billable Roster

6.2.1.2.1. The Contractor is responsible for confirming with the VA, Veterans who no longer should be included on the billable roster at the Contractor's site. This includes Veterans who have died, moved to other areas, have decided to receive their primary care elsewhere, or whom the Contractor has determined have not received a proper Vesting Exam Visit in the previous 12 months (e.g. not have a visit with a Primary Care Provider which merited at least one of the Vesting CPT Codes). Delayed notification that a Veteran should be removed from the billable roster for reasons, in paragraph 6.2.1.2.4 below, will result in offsets being taken against subsequent invoices. Delayed notification includes circumstances in which the Contractor or VA, through no fault of their own, do not receive such information until after the fact.

6.2.1.2.2. In the event that a Veteran has a legitimate complaint and demands disenrollment for cause, payment shall be discontinued the month after the patient is reassigned in PCMM and Contractor is notified. If arbitration is necessary, clinical issues will be referred to the Executive Director of the contracted facility and the Vice President, Primary Care Service Line section of the VA. In the event that a decision cannot be reached at the clinical level, referral shall be made to the CO for final determination. This decision shall be binding.

6.2.1.2.3. Contractor, with approval of the Contracting Officer Representative, may disenroll a Veteran (remove from billable roster) for legitimate cause that may include: Repeated disruptive behavior in clinic; Threatening behavior towards Contractor personnel. The Contractor shall contact the COR, or his designated representative, to discuss any issues, including possible removal from the billable roster, due to disruptive Veteran behavior.

6.2.1.2.4. The VA has ultimate authority to remove from the billable roster, at any time, an enrolled Veteran from the responsibility of the Contractor. The VA will notify the Veteran (with the exception of the no show as explained below) and the Contractor of the effective date of removal from the billable roster. Removal of Veterans from the Contractor's responsibility may occur, but not be limited to, the following reasons:

- The Veteran loses eligibility for VA care.
- The VA decides that removal from the billable roster is in the best interest of the Veteran.
- The Veteran was found to have falsified the application for VA services, and approval was based on false information.
- When it is determined that a Veteran has abused the VA system by allowing an ineligible person to utilize the Veteran's identification card to obtain services.
- When it is determined that the Veteran has willfully and repeatedly refused to comply with the Contractor's requirements or VA requirements, subject to federal laws and regulations.
- When it is determined that the Veteran has abused the VA program by using VA identification card to seek or obtain drugs or supplies illegally or for resale, subject to state and federal laws and regulations.

6.2.1.2.5. The Contractor gives written notification to the VA that the Contractor cannot provide the necessary services to the Veteran or establish an appropriate provider Veteran relationship.

6.2.1.2.6. If the Veteran fails to show up for two consecutive appointments, Contractor shall notify the Veteran by letter after second "no show," advising of potential disenrollment from the Outpatient Site of Care (and removal from the billable roster) if Veteran does not contact provider within two (2) weeks of notification. The Contractor shall notify the VA of any Veteran that does not respond to disenrollment notification, immediately after the lapse of the two (2) week period from notification of the Veteran.

- Death of the Veteran.
- When a Veteran moves to another area.
- When a Veteran receives his/her primary care elsewhere.
- The Veteran receives no Vesting Visit treatment from the Contractor within one (1) year of their last visit as defined in this PWS
  NOTE: These circumstances may become known after the fact. Upon discovery of these situations, the Contractor shall credit or reimburse the VA back to the original date of the removal criteria being met for reasons above.
- Referred to the VA Choice or similar Program.

6.2.1.2.7. For Veterans removed from the billable roster under the "per Veteran[patient] per month (PPPM)" capitation payment method, the Contractor shall be paid the monthly capitation rate for the full month in which the date of removal occurred.

6.2.1.2.8. If the Contractor disagrees with a removal from the billable roster, the issue will be referred to the VA Contracting Officer for resolution. Provided that such resolution is consistent with the other terms of the contract, the final decision of the CO is binding.

6.2.1.3. **Monthly Billable Roster and Invoice Reconciliation:** Monthly billable roster and invoice reconciliation shall take place as follows:

6.2.1.3.1. The VA shall present to the Contractor the VA billable roster for the applicable month to be invoiced.

6.2.1.3.2. The Contractor shall reconcile the VA billable roster with its records, negotiate any differences between its records and the VA billable roster, and invoice the VA.

6.2.1.3.3. The VA shall certify the Contractor's invoice.

~~6.2.1.3.4.~~ No later than the seventh (7th) workday of each month, the VA Coordinator or the COR (or their designee) will submit to the contractor a list of Veteran names who properly meet the billing criteria. This list is the VA "billable roster" for the applicable month to be invoiced. This list will represent the Veterans for whom the VA is willing to provide payment for the previous month. This list will include the names of all Veterans who have received a valid "vesting" exam from a PCP within the previous 12 calendar months using one or more of the Vesting CPT codes listed earlier in this solicitation / contract. (Example: A list sent to the Contractor on October 7, 2009 will cover the time frame of October 1, 2008 through September 30, 2009.) These "vesting" exams must be completed by an appropriate provider employed by the Contractor and working in that particular site. An appropriate provider can only be a physician trained in Internal Medicine or Family Practice, or a Certified Registered Nurse Practitioner, or a Physician Assistant, or a Psychiatrist (if the psychiatrist actually completes and documents a proper vesting exam and uses a proper vesting CPT code). The list of proper vesting CPT codes is: 99203-99205; 99213-99215; 99243-99245; 99385-99387; or 99395-99397. This billable roster represents all Veterans seen in a "vesting" appointment in the previous 12 months minus any Veterans who may have been seen in that timeframe but have, in the meantime, died, moved to another location and do not plan to receive care at the particular site, or have transferred their care to either another site, a VA Medical Center, or to a private medical practitioner,

or who meet any of the remaining disenrollment categories. ~~MH vesting exams are good for the time of treatment plan; therefore possibly greater than 12 months. If Veteran is provided a valid MH vesting exam, with or without an associated treatment plan, should the VA pay (or for how long?) if the Veteran does not receive any care following to the valid vesting exam?~~

6.2.1.3.5. The VA will also provide the Contractor with an alphabetically arranged lists of names of Veterans who were removed that month from the billable roster due to death, relocation, transfer of care, failure to be seen in a vesting visit for the previous 12 months and/or any one of the reasons listed above. The list shall also include which disenrollment reason is applicable to the particular disenrolled Veteran.

6.2.1.3.6. Veteran names that come to either the VA' or the Contractor's attention "after the fact" will not only be removed from the current list of invoiced names, but the Contractor shall also credit or reimburse the VA for any previous months that may have passed during which time the VA and/or the Contractor were unaware of the Veteran's demise, relocation, receipt of health care at a different location or any other reason listed in above, for which the VA was paying the Contractor for perceived care.

6.2.1.3.7. The Contractor shall reconcile the VA billable roster with its records. Any perceived discrepancies identified by the Contractor, regarding the VA provided billable roster, will be required to be negotiated between the Contractor and the VA Coordinator/COR or the CO or their designee. The final Arbitrator to any disagreements between the Contactor and the VA regarding this billable roster is CO. CO decisions in this regard are final, provided that such decision is consistent with the other terms of the contract.

6.2.1.3.8. Upon receipt of an electronic invoice from the Contractor, based on the billable roster agreed upon and including supporting data, the VA will certify the invoice for payment. The Contractor shall have 30 calendar days from the date of invoice to justify any additions to the billable roster for the applicable month of invoice. After 30 calendar days, no further changes will be authorized for the applicable month's invoice.

6.2.2. **INVOICING AND PAYMENT**:

6.2.2.1. **Department of Labor Wage Determination** -The Service Contract Act of 1965 and the Department of Labor Wage Determination at attached applies to the resultant contract(s).

6.2.2.2. **Payment in Full.** Costs are responsibility of parent VA contracting this service. The contractor shall accept payment for services rendered under this contract as payment in full. VA beneficiaries shall not under any circumstances be charged nor their insurance companies charged for services rendered by the Contractor, even if VA does not pay for those services. This provision shall survive the termination or ending of the contract. To the extent that the Veteran desires services which are not a VA benefit or covered under the terms of this contract, the Contractor must notify the Veteran that there will be a charge for such service and that the VA will not be responsible for payment. The contractor shall not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, any person or entity other than VA for services provided pursuant to this contract. It shall be considered fraudulent for the Contractor to bill other third party insurance sources (including Medicare) for services rendered to Veteran enrollees under this contract.

6.2.2.3. Payments will only be made for actual services rendered.

6.2.2.4. Payments shall be made monthly, in arrears. The Contractor shall be reimbursed at the capitation rate specified in the Supplies or Services and Prices/Costs Section. The Contractor shall be reimbursed upon receipt of a proper invoice. Invoices must contain the following information:

Invoices must include the following three separate categories:
Total number of listed Veterans from the previous month's invoice.
New Veterans added to the billable roster since the previous month's invoice.
Veterans removed from the billable roster since the previous month's invoice.
Names of Veterans (if any) whose disenrollments generate a credit, the amount of the credit, and the calculation(s) used to arrive at the credit.
The newly enrolled and disenrolled categories will list, alphabetically, each listed Veteran Patient's name followed with his/her social security number and date of first visit and/or date of removal, as appropriate. Invoices shall also reference the following:

Contract Number
Purchase Order Number
Month Being Invoiced
Number of Patients Being Invoiced
Capitation Rate
Total Amount Due
Invoices shall be submitted to:
~~Department of Veterans Affairs~~
~~Financial Services Center~~
~~P.O. Box 149971~~
~~Austin, TX 78714-8971~~

Invoices shall be submitted electronically to the Department of Veterans Affairs Financial Services Center through Tungsten web portal upon successful registration. (See link to review Tungsten registration information)

6.2.2.5. Veteran Patients determined to be ineligible for VA medical care will be billed by VA for the care rendered in accordance with VA regulations. VA shall reimburse the Contractor for one visit for patient or Veteran subsequently deemed ineligible by VA. Reimbursement will be at the Medicare rate in effect on date of service for the state of Tennessee for the CPT codes utilized during the initial visit. In accordance with the Description/Specifications/Work Statement Section, the VA is required to verify Veteran eligibility within twenty-four (24) hours from the time the Contractor requests an eligibility determination for each applicant. CBOC will be notified of Veteran eligibility status within XX days after care was provided to prevent follow-up care for ineligible Veterans.

6.2.2.6. The VA may deny payment for emergency medical services performed locally outside the Contractor's facility if the VA physician reviewing the Veteran's medical record determines that no emergency existed. The Contractor can appeal this determination in writing to the Contracting Officer by submitting supporting documentation. If a dispute still exists after Contractor's documentation is reviewed, the Contractor may file a claim under the Disputes clause of the contract, FAR 52.212-4(d).

6.2.3. ELECTRONIC FUNDS TRANSFER PAYMENT METHOD:

~~6.2.3.1.~~ Payments under this contract will be made by the Electronic Funds Transfer Payment Method. In accordance with FAR 52.232-34, Payment by Electronic Funds Transfer--Other than Central Contractor Registration, the Contractor must provide the requested information by completing the ~~SF 3881~~ VA Form 10091, VA-FSC Vendor File Request Form VA FSC Vendor File Request Form and submitting it to the contracting officer prior to the award of this contract ~~it to Voucher Audit (04XXX), VA USA City USA, fifteen (15) days prior to submission of the first request for payment under this contract~~, unless already enrolled in Electronic Funds Transfer (EFT). The Contractor is also required to register in System for Award Management (SAM) at https://www.sam.gov in accordance with FAR 52.204-7, although payment will not be made through CCR until some future date. ~~Central Contractor Registration (CCR) at http://www.ccr.gov in accordance with FAR 52.204-7, Central Contractor Registration, although payment will not be made through CCR until some future date.~~

6.2.4. PROCEDURE REGARDING THIRD PARTY RESOURCES:

6.2.4.1. The VA shall be entitled to, and shall exercise full subrogation rights and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrolled Veterans under this contract and recover any such liability from the third party. If the Contractor has determined that third party liability exists for part or all of the services provided directly by the Contractor to an enrolled patient, the Contractor shall make reasonable efforts to notify VA for recovery from third party liable sources the value of services rendered. All such cases will be referred to the MCCR Section at VA.

6.2.4.2. VA has the authority to bill insurance carriers for treatment provided to Veterans for non-service related conditions. Veterans presenting for care will be asked by the Contractor's staff to provide their insurance and/or Medicare card(s). Per the national mandate, the Contractor's staff will then scan the insurance cards (front and back) into the DSS program for processing. In the event the card is not able to be scanned, then the Contractor will enter the information manually. The copy of the card must be faxed no later than the end of the second business day the Veteran is seen. The system automatically requires update of this data every six months (180 days) unless the Veteran identifies a change in his insurance status. Contractor is not liable for data older than 6 months if Veteran has not visited. The Contractor shall review the health insurance information at the time of each clinic visit. The Contractor shall provide the VA with Veteran treatment information on a daily basis in order to facilitate third party billing. The Contractor shall also provide copies of medical records, at no charge, when requested by the VA to support billing.

6.2.4.3. The Contractor shall obtain, as required by 38 U.S.C. 7332, a timely special consent for any medical treatment for drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia, to a Veteran with health insurance. A special consent from the Veteran is needed to allow VA to release bills and medical records associated with the treatment. This release of Information Form (VA# 10-5345 http://www.va.gov/vaforms/medical/pdf/vha-10-5345-fill.pdf&sa=U&ei=mw41UM3oLqbI2AWch4HwBw&ved=0CBIQFjAA&usg=AFQjCNHAqetaMIvcgLUkzUyfyRSOz0Dmnw) should be sent by the Contractor to the TVHS VAMC at the following address to be scanned by VAMC personnel into the patient's medical record: Fax to MSCPAC, Facility Revenue Section at 615-225-5436. If the Veteran refuses to consent, the Contractor shall document the refusal and notify the Facility Revenue Department at 615-225-4916.

6.3. **CONTRACTOR SECURITY REQUIREMENTS (HANDBOOK 6500.6)-** *PLEASE BE SURE THAT YOU RETRIEVE AND SELECT THE VA APPROVED LANGUAGE FROM each SECTION AS APPLICABLE- what follows is an example of language that your IPT may select in consultation with your ISO. The Acquisition Planning Team must complete the VA Handbook 6500.6 Appendix A checklist ("CHECKLIST FOR INFORMATION SECURITY IN THE INITIATION PHASE OF ACQUISITIONS"). Some organizations have established online systems for this process. For 100% contractor-managed and supported facilities, questions 1 through 4 should be answered "yes." Answers to question 5-7 will vary, but will probably be "no." Answering "yes" to question 4 triggers a requirement to include language from VA Handbook 6500.6 Appendices B and C into the contract. . Security clauses 1, 2, 3, 6, 7 and 9 would normally apply since VA would be providing IT and equipment. Security clauses 4, 5 & 8 would be optional based on the level of support provided by contractor(s). That language is as follows:* The contractor, their personnel, and their subcontractors shall be subject to the Federal laws, regulations, standards, and VA Directives and Handbooks regarding information and information system security as delineated in this contract.

1. GENERAL

Contractors, contractor personnel, subcontractors, and subcontractor personnel shall be subject to the same Federal laws, regulations, standards, and VA Directives and Handbooks as VA and VA personnel regarding information and information system security.

2. ACCESS TO VA INFORMATION AND VA INFORMATION SYSTEMS

a. A contractor/subcontrator shall request logical (technical) or physical access to VA information and VA information systems for their employees, subcontractors, and affiliates only to the extent necessary to perform the services specified in the contract, agreement, or task order.

b. All contractors, subcontractors, and third-party servicers and associates working with VA information are subject to the same investigative requirements as those of VA appointees or employees who have access to the same types of information. The level and process of background security investigations for contractors must be in accordance with VA Directive and Handbook 0710, Personnel Suitability and Security Program. The Office for Operations, Security, and Preparedness is responsible for these policies and procedures.

c. Contract personnel who require access to national security programs must have a valid security clearance. National Industrial Security Program (NISP) was established by Executive Order 12829 to ensure that cleared U.S. defense industry contract personnel safeguard the classified information in their possession while performing work on contracts, programs, bids, or research and development efforts. The Department of Veterans Affairs does not have a Memorandum of Agreement with Defense Security Service (DSS). Verification of a Security Clearance must be processed through the Special Security Officer located in the Planning and National Security Service within the Office of Operations, Security, and Preparedness.

d. Custom software development and outsourced operations must be located in the U.S. to the maximum extent practical. If such services are proposed to be performed abroad and are not disallowed by other VA policy or mandates, the contractor/subcontractor must state where all non-U.S. services are provided and detail a security plan, deemed to be acceptable by VA, specifically to address mitigation of the resulting problems of communication, control, data protection, and so forth. Location within the U.S. may be an evaluation factor.

e. The contractor or subcontractor must notify the Contracting Officer immediately when an employee working on a VA system or with access to VA information is reassigned or leaves the contractor or subcontractor's employ. The Contracting Officer must also be notified immediately by the contractor or subcontractor prior to an unfriendly termination.

3. VA INFORMATION CUSTODIAL LANGUAGE

a. Information made available to the contractor or subcontractor by VA for the performance or administration of this contract or information developed by the contractor/subcontractor in performance or administration of the contract shall be used only for those purposes and shall not be used in any other way without the prior written agreement of the VA. This clause expressly limits the contractor/subcontractor's rights to use data as described in Rights in Data - General, FAR 52.227-14(d) (1).

b. VA information should not be co-mingled, if possible, with any other data on the contractors/subcontractor's information systems or media storage systems in order to ensure VA requirements related to data protection and media sanitization can be met. If co-mingling must be allowed to meet the requirements of the business need, the contractor must ensure that VA's information is returned to the VA or destroyed in accordance with VA's sanitization requirements. VA reserves the right to conduct on site inspections of contractor and subcontractor IT resources to ensure data security controls, separation of data and job duties, and destruction/media sanitization procedures are in compliance with VA directive requirements.

c. Prior to termination or completion of this contract, contractor/subcontractor must not destroy information received from VA, or gathered/created by the contractor in the course of performing this contract without prior written approval by the VA. Any data destruction done on behalf of VA by a contractor/subcontractor must be done in accordance with National Archives and Records Administration (NARA) requirements as outlined in VA Directive 6300, Records and Information Management and its Handbook 6300.1 Records Management Procedures, applicable VA Records Control Schedules, and VA Handbook 6500.1, Electronic Media Sanitization. Self-certification by the contractor that the data destruction requirements above have been met must be sent to the VA Contracting Officer within 30 days of termination of the contract.

d. The contractor/subcontractor must receive, gather, store, back up, maintain, use, disclose and dispose of VA information only in compliance with the terms of the contract and applicable Federal and VA information confidentiality and security laws, regulations and policies. If Federal or VA information

confidentiality and security laws, regulations and policies become applicable to the VA information or information systems after execution of the contract, or if NIST issues or updates applicable FIPS or Special Publications (SP) after execution of this contract, the parties agree to negotiate in good faith to implement the information confidentiality and security laws, regulations and policies in this contract.

e. The contractor/subcontractor shall not make copies of VA information except as authorized and necessary to perform the terms of the agreement or to preserve electronic information stored on contractor/subcontractor electronic storage media for restoration in case any electronic equipment or data used by the contractor/subcontractor needs to be restored to an operating state. If copies are made for restoration purposes, after the restoration is complete, the copies must be appropriately destroyed.

f. If VA determines that the contractor has violated any of the information confidentiality, privacy, and security provisions of the contract, it shall be sufficient grounds for VA to withhold payment to the contractor or third party or terminate the contract for default or terminate for cause under Federal Acquisition Regulation (FAR) part 12.

g. If a VHA contract is terminated for cause, the associated BAA must also be terminated and appropriate actions taken in accordance with VHA Handbook 1600.01, Business Associate Agreements. Absent an agreement to use or disclose protected health information, there is no business associate relationship.

h. The contractor/subcontractor must store, transport, or transmit VA sensitive information in an encrypted form, using VA-approved encryption tools that are, at a minimum, FIPS 140-2 validated.

i. The contractor/subcontractor's firewall and Web services security controls, if applicable, shall meet or exceed VA's minimum requirements. VA Configuration Guidelines are available upon request.

j. Except for uses and disclosures of VA information authorized by this contract for performance of the contract, the contractor/subcontractor may use and disclose VA information only in two other situations: (i) in response to a qualifying order of a court of competent jurisdiction, or (ii) with VA's prior written approval. The contractor/subcontractor must refer all requests for, demands for production of, or inquiries about, VA information and information systems to the VA contracting officer for response.

k. Notwithstanding the provision above, the contractor/subcontractor shall not release VA records protected by Title 38 U.S.C. 5705, confidentiality of medical quality assurance records and/or Title 38 U.S.C. 7332, confidentiality of certain health records pertaining to drug addiction, sickle cell anemia, alcoholism or alcohol abuse, or infection with human immunodeficiency virus. If the contractor/subcontractor is in receipt of a court order or other requests for the above mentioned information, that contractor/subcontractor shall immediately refer such court orders or other requests to the VA contracting officer for response.

l. For service that involves the storage, generating, transmitting, or exchanging of VA sensitive information but does not require C&A or an MOU-ISA for system interconnection, the contractor/subcontractor must complete a Contractor Security Control Assessment (CSCA) on a yearly basis and provide it to the COTR.

4. INFORMATION SYSTEM DESIGN AND DEVELOPMENT

a. Information systems that are designed or developed for or on behalf of VA at non-VA facilities shall comply with all VA directives developed in accordance with FISMA, HIPAA, NIST, and related VA security and privacy control requirements for Federal information systems. This includes standards for the protection of electronic PHI, outlined in 45 C.F.R. Part 164, Subpart C, information and system security categorization level designations in accordance with FIPS 199 and FIPS 200 with implementation of all baseline security controls commensurate with the FIPS 199 system security categorization (reference Appendix D of VA Handbook 6500, VA Information Security Program). During the development cycle a Privacy Impact Assessment (PIA) must be completed, provided to the COTR, and approved by the VA Privacy Service in accordance with Directive 6507, VA Privacy Impact Assessment.

b. The contractor/subcontractor shall certify to the COTR that applications are fully functional and operate correctly as intended on systems using the VA Federal Desktop Core Configuration (FDCC), and the

common security configuration guidelines provided by NIST or the VA. This includes Internet Explorer 7 configured to operate on Windows XP and Vista (in Protected Mode on Vista) and future versions, as required.

c. The standard installation, operation, maintenance, updating, and patching of software shall not alter the configuration settings from the VA approved and FDCC configuration. Information technology staff must also use the Windows Installer Service for installation to the default "program files" directory and silently install and uninstall.

d. Applications designed for normal end users shall run in the standard user context without elevated system administration privileges.

e. The security controls must be designed, developed, approved by VA, and implemented in accordance with the provisions of VA security system development life cycle as outlined in NIST Special Publication 800-37, Guide for Applying the Risk Management Framework to Federal Information Systems, VA Handbook 6500, Information Security Program and VA Handbook 6500.5, Incorporating Security and Privacy in System Development Lifecycle.

f. The contractor/subcontractor is required to design, develop, or operate a System of Records Notice (SOR) on individuals to accomplish an agency function subject to the Privacy Act of 1974, (as amended), Public Law 93-579, December 31, 1974 (5 U.S.C. 552a) and applicable agency regulations. Violation of the Privacy Act may involve the imposition of criminal and civil penalties.

g. The contractor/subcontractor agrees to:

(1) Comply with the Privacy Act of 1974 (the Act) and the agency rules and regulations issued under the Act in the design, development, or operation of any system of records on individuals to accomplish an agency function when the contract specifically identifies:

(a) The Systems of Records (SOR); and

(b) The design, development, or operation work that the contractor/subcontractor is to perform;

(2) Include the Privacy Act notification contained in this contract in every solicitation and resulting subcontract and in every subcontract awarded without a solicitation, when the work statement in the proposed subcontract requires the redesign, development, or operation of a SOR on individuals that is subject to the Privacy Act; and

(3) Include this Privacy Act clause, including this subparagraph (3), in all subcontracts awarded under this contract which requires the design, development, or operation of such a SOR.

h. In the event of violations of the Act, a civil action may be brought against the agency involved when the violation concerns the design, development, or operation of a SOR on individuals to accomplish an agency function, and criminal penalties may be imposed upon the officers or employees of the agency when the violation concerns the operation of a SOR on individuals to accomplish an agency function. For purposes of the Act, when the contract is for the operation of a SOR on individuals to accomplish an agency function, the contractor/subcontractor is considered to be an employee of the agency.

(1) "Operation of a System of Records" means performance of any of the activities associated with maintaining the SOR, including the collection, use, maintenance, and dissemination of records.

(2) "Record" means any item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and contains the person's name, or identifying number, symbol, or any other identifying particular assigned to the individual, such as a fingerprint or voiceprint, or a photograph.

(3) "System of Records" means a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

i. The vendor shall ensure the security of all procured or developed systems and technologies, including their subcomponents (hereinafter referred to as "Systems"), throughout the life of this contract and any

extension, warranty, or maintenance periods. This includes, but is not limited to workarounds, patches, hotfixes, upgrades, and any physical components (hereafter referred to as Security Fixes) which may be necessary to fix all security vulnerabilities published or known to the vendor anywhere in the Systems, including Operating Systems and firmware. The vendor shall ensure that Security Fixes shall not negatively impact the Systems.

j. The vendor shall notify VA within 24 hours of the discovery or disclosure of successful exploits of the vulnerability which can compromise the security of the Systems (including the confidentiality or integrity of its data and operations, or the availability of the system). Such issues shall be remediated as quickly as is practical, but in no event longer than 3 days.

k. When the Security Fixes involve installing third party patches (such as Microsoft OS patches or Adobe Acrobat), the vendor will provide written notice to the VA that the patch has been validated as not affecting the Systems within 10 working days. When the vendor is responsible for operations or maintenance of the Systems, they shall apply the Security Fixes within 3 days.

l. All other vulnerabilities shall be remediated as specified in this paragraph in a timely manner based on risk, but within 60 days of discovery or disclosure. Exceptions to this paragraph (e.g. for the convenience of VA) shall only be granted with approval of the contracting officer and the VA Assistant Secretary for Office of Information and Technology.

5. INFORMATION SYSTEM HOSTING, OPERATION, MAINTENANCE, OR USE

a. For information systems that are hosted, operated, maintained, or used on behalf of VA at non-VA facilities, contractors/subcontractors are fully responsible and accountable for ensuring compliance with all HIPAA, Privacy Act, FISMA, NIST, FIPS, and VA security and privacy directives and handbooks. This includes conducting compliant risk assessments, routine vulnerablity scanning, system patching and change management procedures, and the completion of an acceptable contingency plan for each system. The contractor's security control procedures must be equivalent, to those procedures used to secure VA systems. A Privacy Impact Assessment (PIA) must also be provided to the COTR and approved by VA Privacy Service prior to operational approval. All external Internet connections to VA's network involving VA information must be reviewed and approved by VA prior to implementation.

b. Adequate security controls for collecting, processing, transmitting, and storing of Personally Identifiable Information (PII), as determined by the VA Privacy Service, must be in place, tested, and approved by VA prior to hosting, operation, maintenance, or use of the information system, or systems by or on behalf of VA. These security controls are to be assessed and stated within the PIA and if these controls are determined not to be in place, or inadequate, a Plan of Action and Milestones (POA&M) must be submitted and approved prior to the collection of PII.

c. Outsourcing (contractor facility, contractor equipment or contractor staff) of systems or network operations, telecommunications services, or other managed services requires certification and accreditation (authorization) (C&A) of the contractor's systems in accordance with VA Handbook 6500.3, Certification and Accreditation and/or the VA OCS Certification Program Office. Government-owned (government facility or government equipment) contractor-operated systems, third party or business partner networks require memorandums of understanding and interconnection agreements (MOU-ISA) which detail what data types are shared, who has access, and the appropriate level of security controls for all systems connected to VA networks.

d. The contractor/subcontractor's system must adhere to all FISMA, FIPS, and NIST standards related to the annual FISMA security controls assessment and review and update the PIA. Any deficiencies noted during this assessment must be provided to the VA contracting officer and the ISO for entry into VA's POA&M management process. The contractor/subcontractor must use VA's POA&M process to document planned remedial actions to address any deficiencies in information security policies, procedures, and practices, and the completion of those activities. Security deficiencies must be corrected within the timeframes approved by the government. Contractor/subcontractor procedures are subject to periodic, unannounced assessments by VA officials, including the VA Office of Inspector General. The physical

security aspects associated with contractor/subcontractor activities must also be subject to such assessments. If major changes to the system occur that may affect the privacy or security of the data or the system, the C&A of the system may need to be reviewed, retested and re-authorized per VA Handbook 6500.3. This may require reviewing and updating all of the documentation (PIA, System Security Plan, Contingency Plan). The Certification Program Office can provide guidance on whether a new C&A would be necessary.

e. The contractor/subcontractor must conduct an annual self assessment on all systems and outsourced services as required. Both hard copy and electronic copies of the assessment must be provided to the COTR. The government reserves the right to conduct such an assessment using government personnel or another contractor/subcontractor. The contractor/subcontractor must take appropriate and timely action (this can be specified in the contract) to correct or mitigate any weaknesses discovered during such testing, generally at no additional cost.

f. VA prohibits the installation and use of personally-owned or contractor/subcontractor-owned equipment or software on VA's network. If non-VA owned equipment must be used to fulfill the requirements of a contract, it must be stated in the service agreement, SOW or contract. All of the security controls required for government furnished equipment (GFE) must be utilized in approved other equipment (OE) and must be funded by the owner of the equipment. All remote systems must be equipped with, and use, a VA-approved antivirus (AV) software and a personal (host-based or enclave based) firewall that is configured with a VA-approved configuration. Software must be kept current, including all critical updates and patches. Owners of approved OE are responsible for providing and maintaining the anti-viral software and the firewall on the non-VA owned OE.

g. All electronic storage media used on non-VA leased or non-VA owned IT equipment that is used to store, process, or access VA information must be handled in adherence with VA Handbook 6500.1, Electronic Media Sanitization upon: (i) completion or termination of the contract or (ii) disposal or return of the IT equipment by the contractor/subcontractor or any person acting on behalf of the contractor/subcontractor, whichever is earlier. Media (hard drives, optical disks, CDs, back-up tapes, etc.) used by the contractors/subcontractors that contain VA information must be returned to the VA for sanitization or destruction or the contractor/subcontractor must self-certify that the media has been disposed of per 6500.1 requirements. This must be completed within 30 days of termination of the contract.

h. Bio-Medical devices and other equipment or systems containing media (hard drives, optical disks, etc.) with VA sensitive information must not be returned to the vendor at the end of lease, for trade-in, or other purposes. The options are:

(1) Vendor must accept the system without the drive;
(2) VA's initial medical device purchase includes a spare drive which must be installed in place of the original drive at time of turn-in; or
(3) VA must reimburse the company for media at a reasonable open market replacement cost at time of purchase.
(4) Due to the highly specialized and sometimes proprietary hardware and software associated with medical equipment/systems, if it is not possible for the VA to retain the hard drive, then;

(a) The equipment vendor must have an existing BAA if the device being traded in has sensitive information stored on it and hard drive(s) from the system are being returned physically intact; and
(b) Any fixed hard drive on the device must be non-destructively sanitized to the greatest extent possible without negatively impacting system operation. Selective clearing down to patient data folder level is recommended using VA approved and validated overwriting technologies/methods/tools. Applicable media sanitization specifications need to be pre-approved and described in the purchase order or contract.
(c) A statement needs to be signed by the Director (System Owner) that states that the drive could not be removed and that (a) and (b) controls above are in place and completed. The ISO needs to maintain the documentation.

i. Document destruction shall be performed in accordance to VA Directive 6371 (Destruction of Temporary Paper Records) by a vendor who is certified by the National Association for Information Destruction (NAID).

6. PRIVACY AND INFORMATION SECURITY INCIDENT INVESTIGATION

a. The term "privacy or information security incident" means an event that has, or could have, resulted in unauthorized access to, loss or damage to VA assets, or sensitive information, or an action that breaches VA security procedures. The contractor/subcontractor shall immediately notify the COTR within one hour of discovery and simultaneously, the designated ISO and Privacy Officer for the contract of any known or suspected security/privacy incidents, or any unauthorized disclosure of sensitive information, including that contained in system(s) to which the contractor/subcontractor has access.

b. To the extent known by the contractor/subcontractor, the contractor/subcontractor's notice to VA shall identify the information involved, the circumstances surrounding the incident (including to whom, how, when, and where the VA information or assets were placed at risk or compromised), and any other information that the contractor/subcontractor considers relevant.

c. With respect to unsecured protected health information, the business associate is deemed to have discovered a data breach when the business associate knew or should have known of a breach of such information. Upon discovery, the business associate must notify the covered entity of the breach. Notifications need to be made in accordance with the executed business associate agreement.

d. In instances of theft or break-in or other criminal activity, the contractor/subcontractor must concurrently report the incident to the appropriate law enforcement entity (or entities) of jurisdiction, including the VA OIG and Security and Law Enforcement. The contractor, its employees, and its subcontractors and their employees shall cooperate with VA and any law enforcement authority responsible for the investigation and prosecution of any possible criminal law violation(s) associated with any incident. The contractor/subcontractor shall cooperate with VA in any civil litigation to recover VA information, obtain monetary or other compensation from a third party for damages arising from any incident, or obtain injunctive relief against any third party arising from, or related to, the incident.

7. LIQUIDATED DAMAGES FOR DATA BREACH

a. Consistent with the requirements of 38 U.S.C. §5725, a contract may require access to sensitive personal information. If so, the contractor is liable to VA for liquidated damages in the event of a data breach or privacy incident involving any SPI the contractor/subcontractor processes or maintains under this contract.

b. The contractor/subcontractor shall provide notice to VA of a "security incident" as set forth in the Security Incident Investigation section above. Upon such notification, VA must secure from a non-Department entity or the VA Office of Inspector General an independent risk analysis of the data breach to determine the level of risk associated with the data breach for the potential misuse of any sensitive personal information involved in the data breach. The term 'data breach' means the loss, theft, or other unauthorized access, or any access other than that incidental to the scope of employment, to data containing sensitive personal information, in electronic or printed form, that results in the potential compromise of the confidentiality or integrity of the data. Contractor shall fully cooperate with the entity performing the risk analysis. Failure to cooperate may be deemed a material breach and grounds for contract termination.

c. Each risk analysis shall address all relevant information concerning the data breach, including the following:

(1) Nature of the event (loss, theft, unauthorized access);
(2) Description of the event, including:
(a) date of occurrence;
(b) data elements involved, including any PII, such as full name, social security number, date of birth, home address, account number, disability code; (3) Number of individuals affected or potentially affected;
(4) Names of individuals or groups affected or potentially affected;

(5) Ease of logical data access to the lost, stolen or improperly accessed data in light of the degree of protection for the data, e.g., unencrypted, plain text;
(6) Amount of time the data has been out of VA control;
(7) The likelihood that the sensitive personal information will or has been compromised (made accessible to and usable by unauthorized persons);
(8) Known misuses of data containing sensitive personal information, if any;
(9) Assessment of the potential harm to the affected individuals;
(10) Data breach analysis as outlined in 6500.2 Handbook, Management of Security and Privacy Incidents, as appropriate; and
(11) Whether credit protection services may assist record subjects in avoiding or mitigating the results of identity theft based on the sensitive personal information that may have been compromised.

d. Based on the determinations of the independent risk analysis, the contractor shall be responsible for paying to the VA liquidated damages in the amount of $37.50 per affected individual to cover the cost of providing credit protection services to affected individuals consisting of the following:
(1) Notification;
(2) One year of credit monitoring services consisting of automatic daily monitoring of at least 3 relevant credit bureau reports;
(3) Data breach analysis;
(4) Fraud resolution services, including writing dispute letters, initiating fraud alerts and credit freezes, to assist affected individuals to bring matters to resolution;
(5) One year of identity theft insurance with $20,000.00 coverage at $0 deductible; and
(6) Necessary legal expenses the subjects may incur to repair falsified or damaged credit records, histories, or financial affairs.

8. SECURITY CONTROLS COMPLIANCE TESTING
On a periodic basis, VA, including the Office of Inspector General, reserves the right to evaluate any or all of the security controls and privacy practices implemented by the contractor under the clauses contained within the contract. With 10 working-day's notice, at the request of the government, the contractor must fully cooperate and assist in a government-sponsored security controls assessment at each location wherein VA information is processed or stored, or information systems are developed, operated, maintained, or used on behalf of VA, including those initiated by the Office of Inspector General. The government may conduct a security control assessment on shorter notice (to include unannounced assessments) as determined by VA in the event of a security incident or at any other time.

9. TRAINING
a. All contractor employees and subcontractor employees requiring access to VA information and VA information systems shall complete the following before being granted access to VA information and its systems:
(1) Sign and acknowledge (either manually or electronically) understanding of and responsibilities for compliance with the Contractor Rules of Behavior, Appendix E relating to access to VA information and information systems;
(2) Successfully complete the VA Cyber Security Awareness and Rules of Behavior training and annually complete required security training;
(3) Successfully complete the appropriate VA privacy training and annually complete required privacy training; and
(4) Successfully complete any additional cyber security or privacy training, as required for VA personnel with equivalent information system access [to be defined by the VA program official and provided to the contracting officer for inclusion in the solicitation document – e.g., any role-based information security training required in accordance with NIST Special Publication 800-16, Information Technology Security Training Requirements.]

b. The contractor shall provide to the contracting officer and/or the COTR a copy of the training certificates and certification of signing the Contractor Rules of Behavior for each applicable employee within 1 week of the initiation of the contract and annually thereafter, as required.

c. Failure to complete the mandatory annual training and sign the Rules of Behavior annually, within the timeframe required, is grounds for suspension or termination of all physical or electronic access privileges and removal from work on the contract until such time as the training and documents are complete.

10. SECURITY SYSTEMS

Background

Homeland Security Presidential Directive 12 (HSPD-12) requires federal agencies to issue secure and reliable identification to all employees and contractors. FIPS Publication 201-1 -Personal Identify Verification (PIV) of Federal Employees and Contractors, issued by NIST, establishes the technical specifications for the smart cards that respond to this requirement.

HSPD-12 requires Federal agencies to provide a common ID credential system for all federal employees and contractors. PIV badges are electronically verifiable and protected by digital certificates, biometric data, and a PIN code. These credentials are issued, tracked, and revoked from a central management system and require applicant background checks.

On February 3, 2011, the Office of Management and Budget (OMB) released Memorandum 11-11, Continued Identification of Homeland Security Presidential Directive (HSPD) 12 that requires all federal agency systems be enabled to use PIV credentials in accordance with NIST guidelines. OMB directs agencies to use PIV badges in daily operations and integrate centrally managed PIV badge systems with the physical access control systems . PACS readers must, at a minimum, extract unique token identifier information from the PIV badge and by FY 2012 the existing federal physical and logical access control systems must be upgraded to use PIV credentials.

2013 to present, the TVHS has been upgrading facility wide to meet the HSPD-12 system and infrastructure requirements. This has manifested itself through Department of Veterans Affairs Central Office, OSP/HSPD-12 PMO/PACS funded projects. The HSPD-12 compliance upgrade /replacement project is currently in phase II; upgrading Video systems and fully integrating security systems. To this end, the HSPD-12 requirements also extend to all ancillary TVHS facilities and properties.

OSP/HSPD-12 PMO/PACS has standardized TVHS Security system Components.

All Security Systems Shall conform to the following requirements:

1. VA Directive 0735 Homeland Security Presidential Directive 12 (HSPD-12)

2. All PACS components shall be procured in compliance with HSPD-12 requirements in current Federal Acquisition Regulations (FAR) and, where applicable, are on the General Services Administration (GSA) Approved Products List.

3. VA handbook 0730 latest edition.

The lessor shall design, install, and maintain all Security Systems covered in these sections to and in conformance with Government design guides, regulations and directives.

Contractors, contractor personnel, subcontractors, and subcontractor personnel shall be subject to the same Federal laws, regulations, standards, and VA Directives and Handbooks as VA and VA personnel regarding information and information system security

Technical review shall be coordinated with the Government security representative, at the direction of the Contracting Officer, prior to installation. System testing and acceptance shall be conducted by the Government prior to occupancy. This system shall comply with the Architectural Barriers Act, section F230.0.

PHYSICAL ACCESS CONTROL SYSTEM (PACS) VA PIV

LESSOR PROVIDED DESIGN, INSTALLATION, AND MAINTENANCE

The Physical Access Control System (PACS) shall include, but not be limited to: PIV card readers, keypads, biometrics, electromagnetic locks and strikes, and electronic security management system (SMS). PACS devices shall be used for the purpose of controlling access and monitoring building entrances, sensitive areas, mission critical asset areas, and alarm conditions from an access control perspective. This includes maintaining control over defined areas such as site access points, parking lot areas, building perimeter, and interior areas that are monitored from a centralized SCC. PACS shall be able to be fully integrated with other security subsystems using direct hardwire or computer interface.

All new systems must be capable of Seamless integration and interoperability with TVHS existing Software House C-cure 9000 PACS system. Tyco IS is the TVHS PACS installer and they also have a current, in-place, on-site maintenance contract for all things connected to the TVHS PACS. The HSPD-12 system is the integration point for all other Physical Security systems (ex: IP Video Security Surveillance System, IDS, emergency warning/evacuation, etc.…) on campus, CBOCs and external facilities. The systems were installed by Tyco IS and are currently under maintenance contracts. Any and all components of the Security System shall be functionally identical or identical when product name is specified with the existing security systems and shall be coordinated with Tyco IS for seamless integration. All Software Service Agreements (SSA) shall be provided.

Approved system components:

a. System and Software: Software House CCURE 9000 iStar Pro

b. Card Readers: HID pivClass PR 40and RPK 40 reader's 75 bit readers.

Preferred vendor: Tyco IS is the TVHS Physical Access Control System (PACS) installer and who also has a current, in place, on-site maintenance contract for all things connected to the TVHS PACS. Warranties must be observed.

Security System Maintenance Criteria: The Lessor, in consultation and coordination with a security provider, either internal or external, as determined by the Lease Contracting Officer, and the Government security representative, shall implement a preventive maintenance program for all security systems the Lessor has installed. Any critical component that becomes inoperable must be replaced or repaired by the Lessor within 2 business days with an 8 hour call back after being notified. Critical components are those required to provide security (IDS, CCTV, access control, etc.) for a perimeter access point or critical area. "Replacement" may include implementing other temporary measures in instances where the replacement or repair is not achievable within the specified time frame (e .g. a temporary barrier to replace an inoperable pop-up vehicle barrier, etc.). Failure by the Lessor to provide sufficient replacement measures within the timeframe identified above may result in the Government's providing guard service, the cost of which must be reimbursed by the Lessor.

Electronic Security Management System (SMS):

The SMS shall allow the configuration of an enrollment and badging, alarm monitoring, administrative, asset management, digital video management, intrusion detection, visitor enrollment, remote access level management,

and integrated security workstations or any combination thereof. Entry control software shall allow for programming of the PACS via a CPU. All software shall be updated per manufacturer's instructions. Network interface devices shall consist of all hardware and software required to allow for full interface with other security subsystems via a CPU. All Software Service Agreements (SSA) shall be provided.

CLOSED CIRCUIT TELEVISION SYSTEM (CCTV)

LESSOR PROVIDED DESIGN, INSTALLATION, AND MAINTENANCE

The lessor shall design, install, and maintain a Closed Circuit Television (CCTV) system as described in this section. The CCTV system will support the entry control system (at entrances and exits to the space), with time lapse video recording, that will allow Government employees to view and communicate remotely with visitors before allowing access to the Space. As determined by the Government the CCTV system shall provide unobstructed coverage of designated pedestrian entrances and exits. Technical review of the proposed system shall be coordinated with the Government security representative, at the direction of the Contracting Officer prior to installation. CCTV system testing and acceptance shall be conducted by the Government prior to occupancy. The CCTV system shall comply with the Architectural Barriers Act, section F230.0. Government specifications are available from the Lease Contracting Officer. CCTV system components which fail or require maintenance or which fail during testing should be serviced in accordance with the Security System Maintenance Criteria listed below. The Lessor will provide Time-lapse video recordings (digital storage). The Government will centrally monitor the CCTV Surveillance System. System shall be provided to monitor building entrances, restricted areas, mission critical asset areas, and alarm conditions. CCTV system shall be used for surveillance and observations of defined exterior areas, such as site and roadway access points, parking lots, and building perimeter, and interior areas from a centralized police operations room or security control center. The design, installation, and use of CCTV cameras shall support the visual identification and surveillance of persons, vehicles, assets, incidents, and defined locations. All Software Service Agreements (SSA) shall be provided.

Approved system components:

a. Camera specifications: American Dynamics, Illustra 610 Indoor HD 1080p minidome, TDN, WDR, 3-9mm varifocal, PoE, white, clear dome and Outdoor/Indoor HD1080p minidome,TDN,WDR,9-40mm lens, vandal resistant, PoE heater. Or equal.

b. Wiring/Cable specifications: 24-4P UTP-CMP SOL BC CAT5E FRPO/FEP/FRLSPVC GRAY (plenum rated) .

c. Digital Video Recorder (DVR) American Dynamics. DVR will be rack mountable and will reside in existing standard 19" IT Network Rack by others.

d. UPS information: SMART-UPS 1500VA RACKMOUNT 2U LINE-INTERACTIVE BLACK USB.

All systems must be capable of Seamless integration and operation with TVHS existing Software House C-cure 9000 PACS system.

Security System Maintenance Criteria: The Lessor, in consultation and coordination with a security provider, either internal or external, as determined by the Lease Contracting Officer, and the Government security representative, shall implement a preventive maintenance program for all security systems the Lessor has installed. Any critical component that becomes inoperable must be replaced or repaired by the Lessor within 2 business days with an 8 hour call back after being notified. Critical components are those required to provide security (IDS, CCTV, access control, etc.) for a perimeter access point or critical area. "Replacement" may include implementing other temporary

measures in instances where the replacement or repair is not achievable within the specified time frame (e .g. a temporary barrier to replace an inoperable pop-up vehicle barrier, etc.). Failure by the Lessor to provide sufficient replacement measures within the timeframe identified above may result in the Government's providing guard service, the cost of which must be reimbursed by the Lessor.

INTRUSION DETECTION SYSTEM (IDS)

LESSOR PROVIDED DESIGN, INSTALLATION, AND MAINTENANCE

The IDS shall include motion detection, glass break, and door contact sensors, among other devices. These devices provide alternative methods to detect actual or attempted intrusion into protected areas through the use of alarm components, monitoring, and reporting systems. The IDS shall have the capability of being integrated with DSPI, PACS, and SSTV systems. All IDS shall meet UL 639 Intrusion Detection Standard. IDS shall be used to monitor the site perimeter, building envelope and entrances, and interior building areas where access is restricted or controlled.

The Lessor shall design, install, and maintain an Intrusion Detection System (IDS) as described in this section. The IDS system may be integral to the PACS. The Government requires an IDS, which will cover perimeter entry and exit doors, and operable ground-floor windows. Basic Security-in-Depth IDS components include : magnetic door switch(s), alarm system keypad, passive infrared sensor(s) (PIR), an alarm panel (to designated monitoring center) and appropriate communication method i.e. telephone and/or Internet connection, glass-break detector, magnetic window switches or shock sensors. Technical review of the proposed system shall be coordinated with the Government security representative, at the direction of the Lease Contracting Officer, prior to installation. System testing and acceptance shall be conducted by the Government prior to occupancy. Basic Security-in-Depth IDS shall be connected to local monitoring company who has the responsibility of notifying the local law enforcement, fire department, EMS, etc.. Monitoring shall be 24/7, 365. Emergency notification lists shall be coordinated with the monitoring station to include all applicable Government and lessor points of contact. Monitoring shall be designed to facilitate a real-time detection of an incident, and to coordinate an active response to an incident. Components which fail or require maintenance or which fail during testing shall be serviced in accordance with the Security System Maintenance Criteria listed below.

Security System Maintenance Criteria: The Lessor, in consultation and coordination with a security provider, either internal or external, as determined by the Lease Contracting Officer, and the Government security representative, shall implement a preventive maintenance program for all security systems the Lessor has installed. Any critical component that becomes inoperable must be replaced or repaired by the Lessor within 2 business days with an 8 hour call back after being notified. Critical components are those required to provide security (IDS, CCTV, access control, etc.) for a perimeter access point or critical area. “Replacement” may include implementing other temporary measures in instances where the replacement or repair is not achievable within the specified time frame (e .g. a temporary barrier to replace an inoperable pop-up vehicle barrier, etc.). Failure by the Lessor to provide sufficient replacement measures within the timeframe identified above may result in the Government's providing guard service, the cost of which must be reimbursed by the Lessor.

PANIC/DURESS ALARM (LYNX VA TVHS COMPUTER NETWORKED SYSTEM)

LESSOR PROVIDED DESIGN, INSTALLATION, AND MAINTENANCE

Duress, Security Phones, and Intercom System (DSPI): The DSPI system is used to provide security intercommunications for access control, emergency assistance, and identification of locations where persons under duress request a security response. All components of the DSPI shall be fully compatible and shall not require the addition of interface equipment or software upgrades to ensure a fully operational system. DSPI shall be fully integrated with other security subsystems. All Software Service Agreements (SSA) shall be provided.

The Lessor shall design, install, and maintain a Panic/Duress alarm system as described in this section. TVHS has recently deployed a Micro Technology Services, Inc. LYNX networked based panic alarm systems connecting TVHS primary facilities located in Nashville and Murfreesboro, Tennessee with Community Based Outpatient clinics and community centers. It is the intent of this section to continue this system initiative by providing LYNX systems for this facility.

LYNX Systems, Micro Technology Services, Inc. System is currently tied into the TVHS Computer network. Software on TVHS computers allows each Personal Computer to be connected to the LYNX system and in turn also connected to the Police Service PACS. The PACS is a Software House/ Tyco CCure 9000 iStar Pro system. All systems must be capable of Seamless integration and operation with TVHS existing Software House C-cure 9000 PACS system. Tyco IS is the TVHS PACS installer and they also have a current, in- place, on-site maintenance contract for all things connected to the TVHS PACS. The LYNX system must be capable of providing duress alarm activation notification via computer, telephone, pager, and portable radio systems. The LYNX system must provide the capability for alarms to be deactivated/reset both remotely and with a key at the site of the alarm. Specific alarm sites located at facilities with VA Police Officer presence must be equipped with a key reset system. Specific alarm sites located at facilities without VA Police presence must be capable of remote or local computer reset. Warranties must be observed.

The lessor in consultation and coordination with the security provider and Government shall conduct security system performance testing semi-annually. Testing must be based on established, consistent agency-specific protocols, documented and furnished to the Contracting Officer. Components which fail or require maintenance or which fail during testing should be serviced in accordance with the Security System Maintenance Criteria listed below.

Security System Maintenance Criteria: The Lessor in consultation and coordination with a security provider, either internal or external, as determined by the Lease Contracting Officer, and the Government security representative shall implement a preventive maintenance program for all security systems they have installed. Any critical component that becomes inoperable must be replaced or repaired within2 business days with an 8 hour call back after being notified. Critical components are those required to provide security (IDS, CCTV. access control, etc.) for a perimeter access point or critical area. "Replacement" may include implementing other temporary measures in instances where the replacement or repair is not achievable within the specified time frame (e.g. a temporary barrier to replace an inoperable popup vehicle barrier, etc.). Failure by the Lessor to provide sufficient replacement measures within the timeframe identified above may result in the Government's providing guard service, the cost of which must be reimbursed by the Lessor.

UNINTERUPTABLE POWER SUPPLY (UPS)

LESSOR PROVIDED DESIGN, INSTALLATION, AND MAINTENANCE

Size, provide, install and maintain Uninterruptable Power Supply (UPS's) Per Department of Veterans Affairs Physical Security Design Manual (PSDM) 9.2.2 Uninterruptible Power Supply (UPS) for the furnished Security Systems/devices. Rack mount where applicable and free standing as required.

General Requirements:

All work shall be performed in full accordance with applicable local and Federal regulations. All equipment and installation shall conform to the VA master specifications. All equipment and installation shall conform to the recommendations of the National Fire Protection Association (NFPA), including the National Electrical Code (NEC). No departures from specification requirements will be permitted without written approval. The Supplier shall use good safety practices while working. All hardware should be installed in such a manner to minimize

damage and maximize patient and employee safety. All equipment and procedures shall conform to OSHA, NEMA, and ANSI Standards and conform to the Standard Building Code and the Standard Mechanical Code. All installations for the TVHS shall conform to VARR and FAR standards. The contractor shall demonstrate the following:

- GSA Schedule 84 – with all products and services (including on-site emergency maintenance) being proposed.
- Specific past performance work at TVHS VA Medical Center facilities for a computerized duress alarm system to ensure consistency at all proposed sites.
- Specific past performance work with TVHS VAMC's Software House CCURE 9000 PACs to ensure seamless integration.
- Past performance of VAMC electronic security system Assessments, Design, Installation, Training, and Maintenance.
- Certification and dealership in all products and services being proposed.
- Company owned and fully certified staff facility to maintain and support on all products proposed.
- Proven 24/7/365 – 4 hour emergency on-site maintenance support for the main campuses and CBOCs.
- GSA HSPD-12 certified systems integrator certification for Software House CCURE 9000 system.
- Certified under the DHS Safety Act for Electronic Security Services

Systems Design:

Approved Products link (FICAM):

https://gsageo.force.com/IDM/IDMFicamProductSearchPage

Department of Veterans Affairs Physical Security Design Manual (PSDM) January 2015

http://www.cfm.va.gov/til/spclRqmts.asp#PHS

Security Door Opening Matrix in Appendix A should be consulted for VA PIV PACS and IDS requirements. Where there is a choice for using Electric Strikes vs Magnetic Locks: The Electric Strike *shall* be used.

Applicable technical references:

VA Handbook 0730 (latest edition)

US Department of Veterans Affairs Office of Construction & Facilities Management Standards for construction.

http://www.cfm.va.gov/til/

The TIA/EIA Standard (latest edition)

Any Questions should be directed in writing to project contracting officer's representative (COR)

Approved system components

Insert Documents

Typical installation drawings

Insert Documents

Police Service Security Contact

Mr. Hall Jenkins, Electronics Engineer, Police Service (07), Tennessee Valley Healthcare System, l.jenkins@va.gov, Cell: (615) 456-9840

Preferred Vendor/ Installer:

Tyco IS is the TVHS PACS installer and who also has a current, in place, on-site maintenance contract for all things connected to the TVHS PACS. Warranties must be observed. Contacts available upon request.

VA HANDBOOK 6500.6
APPENDIX D

CONTRACTOR RULES OF BEHAVIOR
This User Agreement contains rights and authorizations regarding my access to and use of any information assets or resources associated with my performance of services under the contract terms with the Department of Veterans Affairs (VA). This User Agreement covers my access to all VA data whether electronic or hard copy ("Data"), VA information systems and resources ("Systems"), and VA sites ("Sites"). This User Agreement incorporates Rules of Behavior for using VA, and other information systems and resources under the contract.

1. GENERAL TERMS AND CONDITIONS FOR ALL ACTIONS AND ACTIVITIES UNDER THE CONTRACT:

a. I understand and agree that I have no reasonable expectation of privacy in accessing or using any VA, or other Federal Government information systems.

b. I consent to reviews and actions by the Office of Information & Technology (OI&T) staff designated and authorized by the VA Chief Information Officer (CIO) and to the VA OIG regarding my access to and use of any information assets or resources associated with my performance of services under the contract terms with the VA. These actions may include monitoring, recording, copying, inspecting, restricting access, blocking, tracking, and disclosing to all authorized OI&T, VA, and law enforcement personnel as directed by the VA CIO without my prior consent or notification.

c. I consent to reviews and actions by authorized VA systems administrators and Information Security Officers solely for protection of the VA infrastructure, including, but not limited to monitoring, recording, auditing, inspecting, investigating, restricting access, blocking, tracking, disclosing to authorized personnel, or any other authorized actions by all authorized OI&T, VA, and law enforcement personnel.

d. I understand and accept that unauthorized attempts or acts to access, upload, change, or delete information on Federal Government systems; modify Federal government systems; deny access to Federal government systems; accrue resources for unauthorized use on Federal government systems; or otherwise misuse Federal government systems or resources are prohibited.

e. I understand that such unauthorized attempts or acts are subject to action that may result in criminal, civil, or administrative penalties. This includes penalties for violations of Federal laws including, but not limited to, 18 U.S.C. §1030 (fraud and related activity in connection with computers) and 18 U.S.C. §2701 (unlawful access to stored communications).

f. I agree that OI&T staff, in the course of obtaining access to information or systems on my behalf for performance under the contract, may provide information about me including, but not limited to, appropriate unique personal identifiers such as date of birth and social security number to other system administrators, Information Security Officers (ISOs), or other authorized staff without further notifying me or obtaining additional written or verbal permission from me.

g. I understand I must comply with VA's security and data privacy directives and handbooks. I understand that copies of those directives and handbooks can be obtained from the Contracting Officer's Technical Representative (COTR). If the contractor believes the policies and guidance provided by the COTR is a material unilateral change to the contract, the contractor must elevate such concerns to the Contracting Officer for resolution.

h. I will report suspected or identified information security/privacy incidents to the COTR and to the local ISO or Privacy Officer as appropriate.

2. GENERAL RULES OF BEHAVIOR

a. Rules of Behavior are part of a comprehensive program to provide complete information security. These rules establish standards of behavior in recognition of the fact that knowledgeable users are the foundation

of a successful security program. Users must understand that taking personal responsibility for the security of their computer and the information it contains is an essential part of their job.

b. The following rules apply to all VA contractors. I agree to:

(1) Follow established procedures for requesting, accessing, and closing user accounts and access. I will not request or obtain access beyond what is normally granted to users or by what is outlined in the contract.

(2) Use only systems, software, databases, and data which I am authorized to use, including any copyright restrictions.

(3) I will not use other equipment (OE) (non-contractor owned) for the storage, transfer, or processing of VA sensitive information without a VA CIO approved waiver, unless it has been reviewed and approved by local management and is included in the language of the contract. If authorized to use OE IT equipment, I must ensure that the system meets all applicable 6500 Handbook requirements for OE.

(4) Not use my position of trust and access rights to exploit system controls or access information for any reason other than in the performance of the contract.

(5) Not attempt to override or disable security, technical, or management controls unless expressly permitted to do so as an explicit requirement under the contract or at the direction of the COTR or ISO. If I am allowed or required to have a local administrator account on a government-owned computer, that local administrative account does not confer me unrestricted access or use, nor the authority to bypass security or other controls except as expressly permitted by the VA CIO or CIO's designee.

(6) Contractors' use of systems, information, or sites is strictly limited to fulfill the terms of the contract. I understand no personal use is authorized. I will only use other Federal government information systems as expressly authorized by the terms of those systems. I accept that the restrictions under ethics regulations and criminal law still apply.

(7) Grant access to systems and information only to those who have an official need to know.

(8) Protect passwords from access by other individuals.

(9) Create and change passwords in accordance with VA Handbook 6500 on systems and any devices protecting VA information as well as the rules of behavior and security settings for the particular system in question.

(10)Protect information and systems from unauthorized disclosure, use, modification, or destruction. I will only use encryption that is FIPS 140-2 validated to safeguard VA sensitive information, both safeguarding VA sensitive information in storage and in transit regarding my access to and use of any information assets or resources associated with my performance of services under the contract terms with the VA.

(11)Follow VA Handbook 6500.1, Electronic Media Sanitization to protect VA information. I will contact the COTR for policies and guidance on complying with this requirement and will follow the COTR's orders.

(12)Ensure that the COTR has previously approved VA information for public dissemination, including e-mail communications outside of the VA as appropriate. I will not make any unauthorized disclosure of any VA sensitive information through the use of any means of communication including but not limited to e-mail, instant messaging, online chat, and web bulletin boards or logs.

(13)Not host, set up, administer, or run an Internet server related to my access to and use of any information assets or resources associated with my performance of services under the contract terms with the VA unless explicitly authorized under the contract or in writing by the COTR.

(14)Protect government property from theft, destruction, or misuse. I will follow VA directives and handbooks on handling Federal government IT equipment, information, and systems. I will not take VA sensitive information from the workplace without authorization from the COTR.

(15)Only use anti-virus software, antispyware, and firewall/intrusion detection software authorized by VA. I will contact the COTR for policies and guidance on complying with this requirement and will follow the COTR's orders regarding my access to and use of any information assets or resources associated with my performance of services under the contract terms with VA.

(16)Not disable or degrade the standard anti-virus software, antispyware, and/or firewall/intrusion detection software on the computer I use to access and use information assets or resources

associated with my performance of services under the contract terms with VA. I will report anti-virus, antispyware, firewall or intrusion detection software errors, or significant alert messages to the COTR.
(17)Understand that restoration of service of any VA system is a concern of all users of the system.
(18)Complete required information security and privacy training, and complete required training for the particular systems to which I require access.

3. ADDITIONAL CONDITIONS FOR USE OF NON- VA INFORMATION TECHNOLOGY RESOURCES

a. When required to complete work under the contract, I will directly connect to the VA network whenever possible. If a direct connection to the VA network is not possible, then I will use VA approved remote access software and services.

b. Remote access to non-public VA information technology resources is prohibited from publicly-available IT computers, such as remotely connecting to the internal VA network from computers in a public library.

c. I will not have both a VA network line and any kind of non-VA network line including a wireless network card, modem with phone line, or other network device physically connected to my computer at the same time, unless the dual connection is explicitly authorized by the COTR.

d. I understand that I may not obviate or evade my responsibility to adhere to VA security requirements by subcontracting any work under any given contract or agreement with VA, and that any subcontractor(s) I engage shall likewise be bound by the same security requirements and penalties for violating the same.

4. STATEMENT ON LITIGATION

This User Agreement does not and should not be relied upon to create any other right or benefit, substantive or procedural, enforceable by law, by a party to litigation with the United States Government.

5. ACKNOWLEDGEMENT AND ACCEPTANCE

I acknowledge receipt of this User Agreement. I understand and accept all terms and conditions of this User Agreement, and I will comply with the terms and conditions of this agreement and any additional VA warning banners, directives, handbooks, notices, or directions regarding access to or use of information systems or information. The terms and conditions of this document do not supersede the terms and conditions of the signatory's employer and VA.

Print or type your full name
Signature
Last 4 digits of SSN Date
Office Phone
Position Title
Contractor's Company Name

Please complete and return the original signed document to the COTR within the timeframe stated in the terms of the contract.

ATTACHMENTS NEEDED PER PWS

VHA T-21 Implementation Guide

VHA T21
Implementation Guida

Lab User's Guide – TVHS – York Campus

LAB USERS GUIDE
(ACY) 15.doc

Protocols are identified in Radiology Program Memo 132X-20

Immigration Certification form

Attachment 3 -
Contractor Certificati

WORKLOAD Estimates for Primary Care and Mental Health: As of 10-01-16, vested enrollees at the Cookeville and Roane Countys CBOC were:

FY16	CO	RO
Month	**# Patients**	**# Patients**
OCT PC	3889	1285
OCT MH	1014	281
Total		
NOV PC	3991	1315
NOV MH	1021	290
Total		
DEC PC	4161	1336
DEC MH	1037	304
Total		
JAN PC	4224	1345
JAN MH	1043	307
Total		
FEB PC	4269	1344
FEB MH	181	306
Total		
MAR PC	4330	1350
MAR MH	180	322
Total		
APR PC	4378	1358
APR MH	185	73
Total		
MAY PC	4468	1358
MAY MH	192	76
Total		
JUN PC	4494	1367
JUN MH	209	66
Total		
JUL PC	4480	1358
JUL MH	202	136
Total		
AUG PC	4404	1369
AUG MH	233	92
Total		
SEP PC	4346	1403
SEP MH	235	118
Total		

The following tables provide an estimated number of enrolled veterans residing in the counties supported by the Cookeville and Roane County CBOCs.

Cookeville CBOC
Projected Veteran Population BY15 (By County)

Filter Selection: (All Ages)

EOY Enrollees, EOY Veterans and Enrollment Based Mkt Pen by Fiscal Year (Fiscal Year) and Priority Group (Priority) on columns; and Geography (Geography) on rows sub-setted by All Ages

COUNTY	POPULATION CATEGORIES	FY2015			FY2016			FY2017		
		All Priorities	Priority 1-6	Priority 7-8	All Priorities	Priority 1-6	Priority 7-8	All Priorities	Priority 1-6	Priority 7-8
(47035) Cumberland, TN	EOY Enrollees	2,600	1,848	752	2,670	1,905	765	2,739	1,962	777
(47035) Cumberland, TN	EOY Veterans	6,762	4,317	2,446	6,771	4,351	2,421	6,794	4,399	2,395
(47035) Cumberland, TN	Enrollment Based Mkt Pen	50.47%	42.82%	90.05%	51.17%	43.79%	88.23%	51.85%	44.61%	87.95%
(47049) Fentress, TN	EOY Enrollees	730	580	151	746	592	154	758	601	157
(47049) Fentress, TN	EOY Veterans	1,179	720	459	1,182	725	457	1,183	730	453
(47049) Fentress, TN	Enrollment Based Mkt Pen	81.11%	80.52%	83.45%	81.75%	81.64%	82.17%	82.20%	82.38%	81.54%
(47087) Jackson, TN	EOY Enrollees	293	229	64	300	234	66	305	238	67
(47087) Jackson, TN	EOY Veterans	931	576	354	932	580	352	933	583	350
(47087) Jackson, TN	Enrollment Based Mkt Pen	42.86%	39.72%	59.88%	43.48%	40.36%	59.97%	43.85%	40.82%	59.59%
(47133) Overton, TN	EOY Enrollees	710	558	152	721	565	157	729	569	159
(47133) Overton, TN	EOY Veterans	1,731	1,060	670	1,734	1,067	667	1,737	1,074	663
(47133) Overton, TN	Enrollment Based Mkt Pen	55.87%	52.59%	72.45%	56.14%	52.92%	71.91%	56.20%	53.00%	71.67%
(47141) Putnam, TN	EOY Enrollees	2,876	2,109	767	2,925	2,187	738	2,965	2,253	713
(47141) Putnam, TN	EOY Veterans	5,418	3,568	1,851	5,412	3,588	1,824	5,400	3,605	1,794
(47141) Putnam, TN	Enrollment Based Mkt Pen	64.71%	59.11%	87.50%	65.99%	60.95%	87.40%	66.91%	62.48%	86.22%
(47185) White, TN	EOY Enrollees	1,092	809	283	1,105	835	270	1,119	858	261
(47185) White, TN	EOY Veterans	2,124	1,388	736	2,110	1,387	723	2,094	1,386	708
(47185) White, TN	Enrollment Based Mkt Pen	63.44%	58.27%	84.96%	64.80%	60.17%	85.00%	65.94%	61.88%	84.07%

Data Pulled from Pyramid Analytics on 03-02-17

Roane County CBOC
Projected Veteran Population BY15 (By County)

Filter Selection: (All Ages)

EOY Enrollees, EOY Veterans and Enrollment Based Mkt Pen by Fiscal Year (Fiscal Year) and Priority Group (Priority) on columns; and Geography (Geography) on rows sub-setted by All Ages

COUNTY	POPULATION CATEGORIES	FY2015			FY2016			FY2017		
		All Priorities	Priority 1-6	Priority 7-8	All Priorities	Priority 1-6	Priority 7-8	All Priorities	Priority 1-6	Priority 7-8
(47035) Cumberland, TN	EOY Enrollees	2,600	1,848	752	2,670	1,905	765	2,739	1,962	777
(47035) Cumberland, TN	EOY Veterans	6,762	4,317	2,446	6,771	4,351	2,421	6,794	4,399	2,395
(47035) Cumberland, TN	Enrollment Based Mkt Pen	50.47%	42.82%	90.05%	51.17%	43.79%	88.23%	51.85%	44.61%	87.95%
(47129) Morgan, TN	EOY Enrollees	554	444	110	568	455	113	583	468	115
(47129) Morgan, TN	EOY Veterans	1,731	1,042	689	1,733	1,048	685	1,732	1,053	679
(47129) Morgan, TN	Enrollment Based Mkt Pen	45.10%	42.60%	59.03%	45.78%	43.41%	58.72%	46.66%	44.44%	58.53%
(47143) Rhea, TN	EOY Enrollees	1,095	894	201	1,124	920	204	1,147	941	206
(47143) Rhea, TN	EOY Veterans	2,717	1,705	1,012	2,707	1,709	998	2,694	1,713	981
(47143) Rhea, TN	Enrollment Based Mkt Pen	56.14%	52.45%	81.79%	57.31%	53.82%	80.95%	58.27%	54.95%	80.50%
(47145) Roane, TN	EOY Enrollees	2,041	1,569	473	2,100	1,614	487	2,147	1,650	497
(47145) Roane, TN	EOY Veterans	5,431	3,430	2,001	5,418	3,441	1,977	5,413	3,462	1,951
(47145) Roane, TN	Enrollment Based Mkt Pen	51.01%	45.73%	82.62%	52.13%	46.89%	82.76%	52.83%	47.66%	82.64%

Data Pulled from Pyramid Analytics on 03-02-17

All these veterans may not actually be "enrolled" at the Cookeville CBOC or Roane County CBOC but are enrolled within TVHS.

There are eight (8) Priority Groups to which veterans may be assigned after processing. Veterans are not "assigned" to a CBOC but may choose which site to enroll for Primary Care and Mental Health services.

The Government estimates that each patient will make 3.80 visits per contract year to the CBOC.

The numbers of veterans residing in the counties identified above and estimated number of visits per patient per year as stated above are estimates and are to be used for information purposes only. VA in no way guarantees the accuracy of the estimates. Contractor fully understands and agrees that costs for any additional visits above the estimated average visits per unique veteran patient and all primary care services as specified in the Description/Specifications/Work Statement Section are borne by the Contractor, and are included in the capitation rates agreed to by the Contractor in the Schedule of Services and Prices/Costs section.

Patients have the right to receive primary care other than from VA or a CBOC. The VA, however, encourages patients to have only one primary care provider; and it is the VA's expectation that the patient is seen at the VA CBOC at least once per twelve (12) month period, or as often as deemed clinically appropriate by the veteran's CBOC Primary Care Provider (for further guidance, please also refer to VHA Directive 2009-038 dated August 25, 2009.

Statistical Information: Cookeville and Roane County CBOCs

Table c2a – Market Penetration Analysis – Cookeville CBOC

Priority Group	Total VA Existing Users by Priority Group	Total Veteran Population By Priority Group	Market Penetration
1-6	5990	10677	56%
7-8	1940	5765	34%
Total (Priority 1-8)	7930	16442	48%

Table c2b – Market Penetration Analysis – Roane County CBOC

Priority Group	Total VA Existing Users by Priority Group	Total Veteran Population By Priority Group	Market Penetration
1-6	3550	7328	48%
7-8	1012	4210	24%
Total (Priority 1-8)	4562	11538	40%

Age Distribution of Veteran Population for the Cookeville CBOC:

Projected Veteran Population BY15 with graphic (VISN, Market, Sector, County)												
EOY Veterans by Fiscal Year (Fiscal Year) on columns; and Geography (Geography) and Age Range (Age Group) on rows												
			FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
(47035) Cumberland, TN	EOY Veterans	All Ages	6,762	6,771	6,794	6,778	6,766	6,760	6,758	6,749	6,722	6,696
		<45	743	727	715	706	693	686	677	666	658	650
		45-64	1,835	1,781	1,714	1,665	1,617	1,573	1,547	1,516	1,493	1,459
		65-84	3,639	3,692	3,734	3,776	3,814	3,806	3,793	3,773	3,749	3,732
		85+	546	571	631	632	641	696	741	794	823	856
(47049) Fentress, TN	EOY Veterans	All Ages	1,179	1,182	1,183	1,183	1,181	1,179	1,175	1,171	1,166	1,161
		<45	171	169	167	166	164	162	160	159	159	158
		45-64	463	459	454	448	441	435	431	427	418	411
		65-84	478	485	492	496	500	504	503	505	505	503
		85+	67	68	70	73	76	78	80	80	84	89
(47087) Jackson, TN	EOY Veterans	All Ages	931	932	933	934	934	933	931	928	927	926
		<45	226	223	221	220	218	217	216	214	215	214
		45-64	326	324	321	318	313	308	306	303	297	292
		65-84	306	310	315	318	321	323	323	324	324	323
		85+	73	74	76	79	83	84	87	87	91	96
(47133) Overton, TN	EOY Veterans	All Ages	1,731	1,734	1,737	1,737	1,736	1,733	1,729	1,723	1,717	1,711
		<45	302	298	295	292	289	286	284	281	281	280
		45-64	680	675	669	662	652	642	637	631	618	608
		65-84	628	638	647	653	659	664	663	666	666	663
		85+	120	123	126	131	137	140	145	144	151	159
(47141) Putnam, TN	EOY Veterans	All Ages	5,418	5,412	5,400	5,383	5,356	5,329	5,291	5,255	5,212	5,169
		<45	1,081	1,055	1,033	1,020	1,001	986	978	973	968	952
		45-64	1,958	1,916	1,855	1,804	1,749	1,709	1,659	1,600	1,546	1,512
		65-84	2,072	2,087	2,115	2,139	2,178	2,202	2,235	2,247	2,265	2,263
		85+	307	354	397	422	428	432	419	435	433	442
(47185) White, TN	EOY Veterans	All Ages	2,124	2,110	2,094	2,080	2,064	2,049	2,032	2,011	1,991	1,970
		<45	427	417	408	403	395	389	386	384	382	375
		45-64	852	833	806	784	760	742	719	693	669	653
		65-84	768	773	782	789	803	812	824	827	834	832
		85+	77	88	98	104	106	107	103	107	107	109

Age Distribution of Veteran Population for the Roane County CBOC:

Projected Veteran Population BY15 with graphic (VISN, Market, Sector, County)											
EOY Veterans by Fiscal Year (Fiscal Year) on columns; and Geography (Geography) and Age Range (Age Group) on rows											
			FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
(47035) Cumberland, TN	EOY Veterans	All Ages	6,762	6,771	6,794	6,778	6,766	6,760	6,758	6,749	6,722	6,696
		<45	743	727	715	706	693	686	677	666	658	650
		45-64	1,835	1,781	1,714	1,665	1,617	1,573	1,547	1,516	1,493	1,459
		65-84	3,639	3,692	3,734	3,776	3,814	3,806	3,793	3,773	3,749	3,732
		85+	546	571	631	632	641	696	741	794	823	856
(47129) Morgan, TN	EOY Veterans	All Ages	1,731	1,733	1,732	1,728	1,722	1,716	1,709	1,703	1,691	1,680
		<45	311	307	303	300	297	294	291	288	288	286
		45-64	774	769	762	754	743	732	727	720	705	694
		65-84	605	614	623	629	636	642	642	646	648	646
		85+	41	42	43	45	47	48	49	49	52	54
(47143) Rhea, TN	EOY Veterans	All Ages	2,717	2,707	2,694	2,683	2,669	2,648	2,632	2,613	2,594	2,573
		<45	422	413	406	400	393	389	384	378	373	369
		45-64	1,032	1,010	977	954	929	904	888	871	857	837
		65-84	1,181	1,198	1,216	1,233	1,250	1,249	1,247	1,244	1,240	1,238
		85+	83	87	96	96	97	105	112	120	125	130
(47145) Roane, TN	EOY Veterans	All Ages	5,431	5,418	5,413	5,392	5,370	5,351	5,337	5,323	5,300	5,273
		<45	961	940	924	912	896	887	876	861	850	840
		45-64	1,977	1,938	1,875	1,832	1,785	1,739	1,709	1,676	1,650	1,611
		65-84	2,181	2,213	2,253	2,288	2,324	2,329	2,330	2,332	2,329	2,332
		85+	312	326	360	361	366	397	423	454	471	490