1) DEFINITIIONS

a) Peer review is defined to include critical reviews of an episode of care performed by a peer. A peer is a health care professional who has comparable education, training, experience, licensure, clinical privileges, or scope of practice as another health care professional. Peer review, when conducted systematically and credibly, fosters collaborative learning and can result in both immediate and long-term improvements in care by revealing areas for improvement in either provider practice or local processes of care. VHA Directive 1190 describes the current VHA policy on Clinical peer review in detail.

Authority for Peer Review for Quality Management is found in Title 38 United States Code (U.S.C.) 5705, "Confidentiality of Medical Quality Assurance Records" and its implementing regulations. Peer review data collected by the Contractor shall be designated as protected under VHA's Under Secretary for Health, and as such, is subject to the confidentiality provisions of 38 U.S.C. 5705 and its implementing regulations. The term "Contractor" includes any individual hired by the Contractor (including Contractor's employees, agents, affiliates, a subcontractor and its employees or others to whom the Contractor provides the Department of Veterans Affairs (VA) information in the performance of this contract.) Additionally the provisions of 38 U.S.C. 5705 and its implementing regulations apply to the Contractor in the same manner as they apply to VA employees and peer review data gathered by such VA employees.

b) Peer Review for Quality Management is intended to promote confidential and non-punitive assessments of care at the individual clinician level. Although organizational system issues are sometimes identified, the primary goal is overall improvement in the care provided to Veterans through a review of individual clinician decisions and actions. Peer Review for Quality Management fosters a responsive environment where the clinician and clinical leadership can work together to address any opportunities for practice improvement and strong organizational performance. Use of a committee as a single reviewer is not acceptable for the initial peer review to ensure the objectivity of the review. The Peer Review for Quality Management process is to be consistent, timely, credible, comprehensive, useful, non-punitive, and balanced. Peer Review for Quality Management may only be used for improving the quality of health care or utilization of health care resources in VA medical facilities. Its primary focus is whether the clinical decisions and actions of a clinician during a specific clinical encounter met the standard of care.

i) Audit Reviews. Audit reviews are secondary reviews of a sample of episodes of care that have undergone internal Peer Review for Quality Management.

ii) Facility-Requested Reviews. A facility-requested review (FRR) is an external clinical peer review of one or more episodes of care where the facility desires external expertise (e.g., when there are no qualified local peers or if there is a conflict of interest to complete locally).

c) Management Review. A Management Review is any review that is conducted for purposes *other than confidential quality assurance*. Management Reviews are not confidential and privileged under 38 U.S.C. § 5705 and it's implementing regulations and are not considered Quality Management activities. These management reviews may not be protected from legal discovery under FOIA, but the contractor will not be required to be deposed. Outside of routine management reviews, there are two specialized groups of management reviews:

i) Medical Advisory Opinions. Clinical reviews to provide medical advisory opinions related to standard of care determinations. A medical advisory opinion is an essential component of the VA General Counsel's decision to settle or deny a claim. VA regulations, at Title 38 Code of Federal Regulations (CFR) § 14.602(b), provide that Regional Counsel staff are guided by the views of the Under Secretary for Health as to the standard of medical care and treatment, the nature and extent of the injuries, the degree of temporary or permanent disability, the prognosis, the necessity for future treatment or physical rehabilitation, and any other pertinent medical aspects of a claim. Medical advisory opinions are generally protected from discovery in litigation, and are exempt from disclosure under the Freedom of Information Act (FOIA) exemption 5 (Title 5 United States Code (U.S.C.) § 552(b)(5)), by the attorney work-product doctrine codified in Rule 26(b)(3), Federal Rules of Civil Procedure. They are not, however, considered confidential and privileged quality assurance records under 38 U.S.C. § 5705. No disclosure should be made of such opinions without the approval of the Regional Counsel or General Counsel (021B). The opinions are qualitatively different from a peer review. The medical advisory opinion should address in detail all of the questions raised by the General Counsel attorney. Medical issues not identified by General Counsel, but which the reviewer believes are relevant to the episode of care under review should be identified by the reviewer, even if the medical issue was not specifically identified by the General Counsel attorney.

ii) Clinical Appeals. Clinical reviews provide recommendations regarding appropriate and/or reasonable and necessary clinical service was provided and/or denied by VHA. These Clinical appeals may include caregiver support reviews. These reviews are not considered confidential and privileged quality assurance records under 38 U.S.C. § 5705.

d) Triggered Reviews. Certain circumstances, such as outlier status on specific measures of clinical performance, may lead to a 38 U.S.C. § 5705-protected review of one or more episodes of care by an external reviewer.

2) SCOPE OF WORK

The contractor shall provide external expertise and conduct a peer review of selected episodes of care.

a) Peer Review for Quality Management
    i) Audits
        (1) Perform a secondary review of randomly selected previously conducted peer reviews from all VA Medical Centers (VAMC). Cases will be selected using a randomized process, from a pool of cases submitted by each facility each quarter.
    ii) Facility Requested Reviews
b) Management Review
    i) Management Review
    ii) Medical Advisory Opinion
    iii) Clinical Appeals
c) Triggered Reviews
d) Reports
    i) Provide standardized feedback about individual VAMCs and VHA that identifies opportunities to improve care, as well as improve the process of internal peer review. Feedback will be provided in quarterly and annual reports to VA Central Office (VACO). The contractor shall upload reports into a secure shared location.
    ii) Analyze data from the audit of randomly selected cases per VACO instructions and provide a quarterly and annual report to the Risk Management Program (RM).
e) Conduct Inter-Rater Reliability (IRR) studies annually.
    i) Clinical peer reviewers for the Contractor shall undergo an annual process of inter-rater reliability testing, at the Contractor's expense, based on accepted industry standards and a sampling strategy approved by the Contracting Officer's Representative (COR).
    ii) Clinical peer reviewers must achieve an IRR of 0.9 or higher.
        (1) Any Peer Reviewer who fails this test shall be given remediation and reassessed at the expense of the Contractor.
        (2) Failure on the second test shall result in the removal of the reviewer from the pool of eligible reviewers.
    iii) Findings from reliability testing will be made available to the COR.

The vendor may conduct up to 6000 reviews, to be divided between Facility-Requested Reviews, Audit Reviews, Triggered Reviews, and Management Reviews according to VA's needs. The estimated target number of annual reviews per category is listed below:

a) 4250 Audit Reviews
b) 1000 Facility-Requested Reviews
c) 580 Management Reviews
d) 170 Triggered Reviews

3) SERVICE REQUIREMENTS

The Contractor shall perform the following:

a. Peer Reviews are to be conducted by providers in all identified (See ATTACHMENT A - SPECIALTIES) specialties and subspecialties (as defined by the American Board of Medical Specialties), with a contractor provider panel of sufficient depth (i.e. size) in each specialty/subspecialty to meet the volume and demand of the VA. The review panel will include non-physician Providers, such as Physician Assistants (PA), Advanced Practice Nurses (APRN), and Certified Registered Nurse Anesthetists (CRNA), Psychologists, Pharmacists, Registered Nurses, Licensed Vocational Nurses, Social Workers, and other ancillary providers.

i. The panel size shall be greater than 250 clinicians.

ii. Depth at key specialties such as Cardiothoracic Surgery, Interventional Cardiology, Vascular Surgery, Neurosurgery and Mental Health is critical to meeting the needs of VHA. All specialties appearing in Attachment A must have greater than one reviewer each and must have a depth of capacity that is reasonably sufficient to maintain the workload provided for all review categories. Be aware that from time to time an influx of a specialty may occur.
iii. The contractor must have a strategy for expanding the panel size to meet emerging practices, such as robotics.

a) Contractor will provide a list of all reviewers, listing name and specialty vacancies and staff in the hiring queue to include Reconciliation of reviewers through screening through the Health and Human Services Office of Inspector General List of Excluded Individuals and Entities.

c. Peer Reviewer Qualifications:

1) Physician reviewers must be board certified in the specialty for which they are qualified to review according to the American Board of Specialties, and must be in active practice at least 20-hours per month.
2) Non-physician reviewers must be licensed and in active practice at least 20 hours per month.

ii. Possess the relevant clinical expertise necessary to make accurate evaluations about the decisions being reviewed;
iii. Be able to make a fair and credible assessment of the actions taken by a clinician relative to the episode of care under review.

(c) Possess knowledge of current evidence-based standards of care relevant to the case under review.

(d) Complete adequate training regarding the peer review process, responsibilities, and the associated legal and ethical requirements.
v. Be formally trained regarding the clinical peer review process; the responsibilities of the clinical peer reviewer, and the facility's legal and ethical requirements;
vi. Have no direct involvement with the care in question;
vii. Are not employees or contractors of VA providing direct care to Veterans;

viii. Have no conflicts of interest or other factors that might impact the ability to conduct objective, impartial, accurate and informed review;
ix. Is not excluded from receiving payment from any Federal healthcare program confirmed through screening through the Health and Human Services Office of Inspector General List of Excluded Individuals and Entities.

d. Levels of care, in accordance with VHA Directive 1190, must be determined against the following criteria:

i. Level 1 is the level at which the most experienced, competent practitioners would have managed the case in a similar manner.
ii. Level 2 is the level at which most experienced and competent clinicians might have managed the case differently but it remains within the standard of care.
iii. Level 3 is the level at which the most experienced, competent practitioners would have managed the case differently.

Should the directive be updated during contract performance, the contractor will be responsible for conducting reviews according to the revised standards for levels of care.

e. To support the VA peer review reconciliation process:
i. Contractor shall notify VACO RM of cases in which there is a two level discrepancy with the facility review.
ii. Contractor shall provide the discrepancy information upon identification by the contractor.
f. The contractor shall be available on a case-by-case basis for a teleconference call with Veterans Integrated Service Network (VISN), medical center, and RM office staff for further case discussion.

i. At VA request, on a case-by-case basis, the original reviewer/specialist shall be present on the reconciliation conference call as opposed to only the Contractor's medical director. The calls will be limited to 30 minutes. The price paid will be half the unit cost for an audit review.
ii. The medical director shall review the cases for clinical sufficiency and serve as resource for clinical guidance. The medical director shall review the credentialing files and provide any other medical guidance for clinical oversight. The medical director shall participate in reconciliation calls and other conference calls at the request of VA.
iii. The contractor may need to make the reviewer available to confer with VA Regional Counsel attorney if needed for further clarification of information contained in the Medical Advisory Opinion review. For example, if there is ambiguity in the reviewer's opinion or an opinion is provided by the claimant, it may become necessary for the VA Regional Counsel attorney to consult with the reviewer. In this instance, VHA would compensate the contractor for the full cost of those consultative discussions.

g. The contractor's essential administrative personnel shall obtain VA issued PIV Badges to support this requirement. PIV badges shall be obtained in accordance with Homeland Security Personnel Directive (HSPD) requirements.

i. SPECIFIC TASKS AND DELIVERABLES

a. Reviews are due as specified to VHA Monday through Friday, No Later Than (NLT) 3:00PM, Eastern Time (ET). Any reviews submitted after 3:00PM, ET will be considered as received the following business day.

viii. Audit Reviews shall be completed and submitted within 30-calendar days of the start date assigned by VA.

ix. Facility Requested Reviews shall be completed and submitted within 30 calendar of VA designated start date. VA will designate the start date upon receipt of all documents by the contractor, or other information as applicable, necessary to conduct the peer review.

x. Triggered Reviews shall be completed and submitted within 30 calendar days of VA designate start date. VA will designate start date upon receipt of all documents by the contractor, or other information as applicable, necessary to conduct the triggered review. Triggered Reviews shall include an executive summary and support for conclusions based on review of current literature, when relevant.

xi. Management Review shall be completed and submitted within 30 calendar days of VA designated start date. VA will designate start date upon receipt of all documents by the contractor, or other information as applicable, necessary to conduct the management review.

xii. All reviews completed by the contractor shall contain an attestation page that lists the reviewer's name, specialty, and absence of a conflict of interest.

xiii. Contractor shall abide by all government requirements for dissemination of Protected Health Information (PHI) and Personally Identifiable Information (PII). Approved mechanisms are available from the Contracting Officer or COR.

xiv. All reviews completed by the contractor shall be submitted in PDF format.

b. Quarterly Reports: Quarterly reports of audits, triggered reviews, and facility-requested reviews conducted in each quarter shall be due 30 days after the end of each quarter.

ii. Cases shall be reported according to the quarter from which they were sampled. If case(s) is/are not completed in time to be reported on the quarterly report, the quantity of these incomplete cases shall be reported; however, no data from these cases shall be included in the charts, graphs, or analysis of cases. An addendum with incomplete case data shall be attached to the corresponding quarterly report.

iv. Reports shall utilize spreadsheet and graph formats, based on the examples provided by the COR.VA reserves the right to alter the analysis, format, and schema as VA requests.Examples for data presentation graphs can be provided.

vii. The contents of the report shall include:

a) Summary, not to exceed two pages, and must include:

1) Total number of cases accepted by review type and clinical specialty;

2) Number of cases declined by review type and clinical specialty; and

3) Any panel sizes that have deficiencies

b) Audits

1) Total number of audit review cases completed during FY2016 stratified by VISN and facility complexity.

2) Total number of cases by specialty (stratified by specialties, subspecialties, and predetermined factors as defined by VACO RM).

3) Level of care assessed by the external reviewer for audit reviews.

4) Aspects of care causing concern for the overall audit reviews scored at level 2 or level 3 by the external reviewer.

a. By Specialty; and

b. By Complexity Group.

5) Aspects of care cited by the reviewer for audit review cases

a. By Specialty; and

b. By Complexity Group.

c) Discrepancy Report (Only reporting 2-level discrepancies)

1) Comparison between the Peer Review Committee (PRC) determination and the external reviewer assessment of level of care for audit samples.

a. By facility complexity group; and

b. By VISN.

2) Percentage of differences between the PRC determination and the external reviewer assessment of level of care.

a. By facility complexity group; and

b. By VISN.

3) Direction of differences between the PRC determination and the external reviewer assessment of level of care by facility complexity group.

a. By facility complexity group; and

b. By VISN.

d) Facility Requested Reviews

1) Total number of facility requested reviews completed.

a. By VISN; and

b. By facility complexity.

2) Total number of facility requested reviews completed.
   a. By VISN; and
   b. By clinical specialty.

e) Management Reviews
   1) Total number of management reviews completed.
      a. By VISN; and
      b. By facility complexity.
   2) Total number of management reviews completed
      a. By VISN; and
      b. By clinical specialty.
   3) Met or Not met counts.
      a. By VISN; and
      b. By clinical specialty.

f) Triggered Reviews
   1) Total number of facility requested reviews completed.
      a. By VISN; and
      b. By facility complexity.
   2) Total number of facility requested reviews completed.
      a. By VISN; and
      b. By clinical specialty.

g) Audit, Facility Requested, Management, and Trigger Reviews will be trended and compared over rolling four quarters.

h) Raw Data from audit reviews, facility requested reviews, and triggered reviews will be reported separately within the quarterly report. Data will be provided to VACO RM so the following are sortable:
   1) VISN;
   2) Facility;
   3) Clinical Specialty; and
   4) Medical Complexity Group.

d. Annual Report: Contractor will provide a comprehensive annual report, including their internal Inter-Rater Reliability (IRR) findings, 60 days after the end of the fiscal year, ending September 30. An annual report shall also be provided at the end of the contract period of performance should it not coincide with the end of the fiscal year.

iv. The report will include an Executive Summary, not to exceed two pages, as well as the following:

a) Total number of cases accepted by review type and clinical specialty.

b) Number of cases declined by review type and clinical specialty.

c) Any panel sizes that have deficiencies throughout the year.

v. The data will be reported on a yearly basis, and will be trended and compared to the prior two years.

vi. Raw Data from audit reviews, facility requested reviews, and triggered reviews will be reported separately within the annual report. Data will be provided to VACO RM so the following are sortable:

e) VISN;

f) Facility;

g) Clinical Specialty; and
h) Medical Complexity Group.