

PEER REVIEW FOR QUALITY MANAGEMENT

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive sets forth the requirements for initiating, conducting, and documenting Peer Review for Quality Management of clinical care provided by individual health care clinicians in VA medical facilities.

2. SUMMARY OF MAJOR CHANGES:

a. Amendment dated July 19, 2024: Removes the words “or following” from the following sentence: A management review must not occur concurrently with or following a Peer Review for Quality Management for the same episode of care (paragraph 6.b.).

b. As published November 21, 2018, this directive:

(1) Removed the use of committee discussion as an initial peer review.

(2) Stated that management reviews can no longer be conducted concurrently with Peer Reviews for Quality Management for the same episode of care.

(3) Added the responsibilities for the Under Secretary for Health, the Principal Deputy Under Secretary for Health, and the Deputy Under Secretary for Health for Organizational Excellence.

(4) Added a requirement that Peer Reviews for Quality Management for Chiefs of Staff in clinical practice shall be conducted by a reviewer outside the Chief of Staff’s facility and/or supervisory chain of command. The Chief of Staff should not be present if the review is sent to the Peer Review Committee for discussion.

(5) Added an example of a designation memorandum from the VA medical facility Director or designee for Title 38 United States Code 5705 protection at the outset of a review.

(6) Stated that Peer Reviewers must notate one of the nine aspects of care, as written in this directive.

(7) Changed in definition of Level 2 of the Levels of Care.

(8) Removed the requirement of a local policy.

(9) Updated how Peer Review Data is reported.

(10) Clarified aspects of care that were unclear or redundant.

3. RELATED ISSUES: VHA Handbook 1050.01, VHA National Patient Safety

Improvement Handbook; VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports; VHA Handbook 1100.19, Credentialing and Privileging; VHA Directive 2008-077, Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents; VHA Directive 1026, VHA Enterprise Framework for Quality, Safety, and Value.

4. RESPONSIBLE OFFICE: The Office of the Associate Deputy Under Secretary for Health for Quality and Patient Safety (QPS) is responsible for the contents of this directive. Questions may be referred to the Director, Risk Management Program, at 202-461-8340 or vhamedicallegalriskm@va.gov.

5. RESCISSIONS: VHA Directive 2010-025, dated June 3, 2010, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of November 2023. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

/s/ Richard A. Stone, M.D.
Executive in Charge

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on November 27, 2018.

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PEER REVIEW FOR QUALITY MANAGEMENT

1. PURPOSE

This Veterans Health Administration (VHA) directive sets forth the requirements for initiating, conducting, and documenting Peer Review for Quality Management of care provided by individual health care clinicians in VA medical facilities. **NOTE:** *Not all clinical care reviews are conducted for quality management; this directive applies only to peer review activities initiated for quality management purposes that are conducted pursuant to this directive and designated as protected under Title 38 United States Code Section 5705 (38 U.S.C. 5705).* **AUTHORITY:** 38 U.S.C. 5705, 7301(b).

2. BACKGROUND

a. Many other activities may include reviews conducted by peers, but they are not Peer Review for Quality Management and may or may not be protected by 38 U.S.C. 5705. For example, review by a peer may be conducted as part of a management review process that can affect privileges or personnel status, such as Administrative Investigations, Focused Professional Practice Evaluations (FPPE), and Ongoing Professional Practice Evaluations (OPPE). In relation to tort claims, administrative reviews may be conducted to generate Medical Advisory Opinions for review by Office of General Counsel staff for consideration in the claim disposition process. While such reviews are used to evaluate the provision of care by an individual meeting the definition of a peer, the term Peer Review for Quality Management is reserved for the process that is conducted as defined in this directive under the auspices of Quality Management.

b. As stated in 38 U.S.C. 5705, the term “medical quality-assurance program” means with respect to any activity carried out on or after October 7, 1980, a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for improving the quality of medical care or the utilization of health-care resources in VA facilities. Peer Review for Quality Management is a type of focused review; “focused review” is a category of reviews that has been designated by the Under Secretary for Health in this directive and in VHA Directive 2008-077, Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents, dated November 7, 2008, as a confidential and privileged quality management (QM) activity protected by 38 U.S.C. 5705, Confidentiality of Medical Quality-Assurance Records, and its implementing regulations in Title 38 Code of Federal Regulations (CFR) 17.500 through 17.511. Focused reviews can be facility, Veterans Integrated Service Network (VISN), or VA Central Office focused reviews. **NOTE:** *In addition, individually, every Peer Review for Quality Management must be designated by the reviewing office at the outset of the review as 5705-protected to be protected.* Multiple additional requirements must be met for a QM record or document to be confidential and privileged under 38 U.S.C. 5705. Many of the requirements, as well as exclusions from coverage, are described in 38 CFR 17.501.

c. When conducted systematically and credibly, Peer Review for Quality Management can result in both short-term and long-term improvements in patient care by revealing areas for improvement in the provision of health care of one or multiple clinicians. This ultimately contributes to organizational improvements and optimal patient outcomes.

d. 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.

e. 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.

f. When assessing a specific event or issue, the facility should consider whether a 38 U.S.C. 5705-protected QM activity is the appropriate first step. If it is anticipated that administrative personnel actions such as changes in privileges or terms of employment may be indicated, Peer Review for Quality Management is not appropriate, and a Management Review should be chosen (see paragraph 6). As discussed below, use of Peer Review for Quality Management for personnel purposes is prohibited.

g. In most cases, sentinel events, except suicide, do not warrant Peer Review for Quality Management. However, each event should be reviewed to determine if it warrants referral for peer review.

3. DEFINITIONS

a. **Clinician.** For purposes of this directive, a clinician is a health care professional who is authorized to deliver health care exercising autonomous clinical judgment and whose actions are subject to Peer Review for Quality Management. An allied health care professional functioning in a technician role is typically not considered to be exercising autonomous clinical judgment for purposes of Peer Review for Quality Management. Clinical decisions associated with Compensation and Pension examinations cannot be peer-reviewed; concerns can be addressed through the management review process.

NOTE: *This directive does not apply to health care profession trainees acting within the scope of their training program.*

b. **Confidential Quality Management Documents.** Confidential quality management documents are all documents or parts of documents produced by, or for, VA in the process of conducting systematic health care reviews for the purpose of improving the quality of health care or improving the utilization of health care resources, and meet the criteria outlined in VA's Quality Management regulations at 38 CFR 17.500 through 17.511 (e.g., the document must identify either implicitly or explicitly, individual clinicians or other employees, patients, or reviewers).

NOTE: Confidential documents may be released to the Office of Inspector General (OIG) or Office of the General Counsel (OGC) at their request. District Counsel Attorneys and staff are OGC employees. VHA may provide all VHA information, including individually identifiable information to OIG and OGC for any official purpose authorized by law. This includes individually identifiable health information for the purpose of health care oversight (see 45 CFR 164.512(d) and VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016). The Office of the Medical Inspector (OMI), as a component of VHA, has legal authority under applicable Federal privacy laws and regulations to access and use any information, including health information, maintained in VHA records for the purposes of health care operations and health care oversight.

c. **Episode of care.** All services provided to a patient with a clinical problem within a specific period of time across a continuum of care in an integrated system.

d. **External Peer Review Contract.** VHA utilizes the services of a national contractor with expertise in conducting clinical peer review across all clinician disciplines to assist in improving the peer review process conducted by local clinical staff. The term “contractor” includes any individual hired by the contractor (including the contractor’s employees, agents, affiliates, a subcontractor and its employees, or others to whom the contractor provides VA information) in the performance of the contract. 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. The contract typically is used for three subtypes of Peer Reviews for Quality Management:

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

(2) **Facility-Requested Reviews.** A facility-requested review (FRR) is an external clinical Peer Review for Quality Management 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).

(3) **Management Reviews.** Certain circumstances, such as outlier status on specific measures of clinical performance, may lead to a review of one or more episodes of care that is not 38 U.S.C. 5705 protected.

NOTE: Peer reviews conducted by an external contractor are intended to supplement, rather than replace, requests for peer review from other facilities within a VISN.

e. **Levels of Care.** The following Levels of Care are to be used in assessing the clinical decisions and actions of the clinician who is the subject of a Peer Review for Quality Management. A Level of Care must be assigned by the initial reviewer(s) and in the evaluation and discussion of the initial review and the episode of care by the multi-disciplinary Peer Review Committee (PRC).

(1) Level 1 is the level at which most experienced and competent clinicians would have managed the case in a similar manner.

(2) 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.

(3) Level 3 is the level at which most experienced and competent clinicians would have managed the case differently.

f. **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 its implementing regulations and are not considered QM activities. Management review activities include Focused Clinical Care reviews, FPPE and FPPE for Cause, Administrative Investigations, and OPPE.

g. **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.

h. **Peer Reviewer.** A peer reviewer is a health care professional who can make a fair and credible assessment of the actions taken by the clinician relative to the episode of care under review. A factor to consider when selecting a peer reviewer includes, but is not limited to, whether the individual has similar or more advanced education, training, experience, licensure, clinical privileges, or scope of practice. Examples of appropriate peer reviewers may also include: a general surgeon reviewing a gastroenterologist when performing the same procedure; a general surgeon reviewing a physician's assistant assigned to the Surgery Clinic; and a physician who works in Primary Care reviewing a nurse practitioner working as a primary care clinician.

i. **Peer Review for Quality Management.** A Peer Review for Quality Management is a critical review of care performed by a peer conducted in accordance with all applicable laws, regulations, current VHA policies, and this directive. Essential elements of Peer Review for Quality Management include:

(1) Peer evaluation of the care provided by individual clinicians within a selected episode of care.

(2) Identification of learning opportunities for practice improvement and any related improvement actions recommended by the peer review process.

(3) Confidential communication back to the clinicians who were peer reviewed regarding the results and any recommended actions to improve their clinical practice. This communication cannot include initiation of any administrative actions (e.g., modification of clinical privileges). For additional Information, please see Appendix A 2.r.

(4) Identification of system and process issues that may need to be referred and addressed using other types of quality management activities.

j. **Sentinel Event.** The Joint Commission defines a sentinel event as a Patient Safety Event that reaches a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.

k. **Standard of Care.** A standard of care is a diagnostic and/or treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance. It is how similarly qualified clinicians would have managed the patient's care under the same or similar circumstances.

4. POLICY

It is VHA policy that a Peer Review and Quality Management Program is maintained in accordance with this directive and is in compliance with those accrediting and oversight agencies that periodically review VA medical facilities including, but not limited to The Joint Commission.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring that all VHA facilities follow the Peer Review for Quality Management directive.

b. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health is responsible for reviewing Peer Review for Quality Management priorities.

c. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Sustaining the Peer Review for Quality Management Program in coordination with the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value.

(2) Providing oversight of data reported from facilities through VISNs to the Office of Quality, Safety, and Value (QSV).

(3) Communicating clinical Peer Review for Quality Management priorities throughout VHA in coordination with the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value, Chief Medical Officers, and other program offices, as appropriate.

d. **Deputy Under Secretary for Health for Organizational Excellence.** The Deputy Under Secretary for Health for Organizational Excellence is responsible for reporting of data analysis findings on Peer Review for Quality Management program activity within VHA to the Deputy Under Secretary for Health for Operations and Management and the Principal Deputy Under Secretary for Health.

e. **Assistant Deputy Under Secretary for Health for Quality, Safety, and Value.** The Assistant Deputy Under Secretary for Health for Quality, Safety and Value is responsible for:

(1) Sustaining the Peer Review for Quality Management program in coordination with the Deputy Under Secretary for Health for Operations and Management.

(2) Communicating clinical Peer Review for Quality Management priorities throughout VHA in coordination with the Deputy Under Secretary for Health for

Operations and Management, Chief Medical Officers, and other program offices, as appropriate.

(3) Reviewing data analysis related to Peer Review for Quality Management.

(4) Reporting of data analysis findings to the Deputy Under Secretary for Health for Organizational Excellence on Peer Review for Quality Management program activity within VHA.

f. **Director, Risk Management Program.** The Director of the Risk Management Program is responsible for:

(1) Reporting data analysis findings to the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value on Peer Review for Quality Management program activity within VHA.

(2) Providing an analysis of data findings submitted by the VISN Directors related to Peer Review for Quality Management.

(3) Disseminating data analysis findings and trends to VISNs and facility leadership.

(4) Managing the national external Peer Review for Quality Management contract(s) as an avenue to augment VISN and facility audits of the integrity of the VHA Peer Review for Quality Management program, as well as to provide a VISN resource for peer reviews that cannot be obtained locally.

(5) Establishing the external audit process requirements.

g. **Veterans Integrated Service Network Director.** Each VISN Director is responsible for:

(1) Ensuring that implementation of this directive occurs within assigned VHA medical facilities and that the program encompasses care provided throughout the VISN, including community-based outpatient clinics (CBOC).

(2) Establishing oversight processes for Peer Review for Quality Management activities within the VISN, to ensure facilities:

(a) Implement a fair and credible peer review program, and

(b) Establish a mechanism to ensure that identified issues are acted upon until completion.

(3) Ensuring annual and ad hoc reviews, as appropriate, of the Peer Review for Quality Management program are completed at all VISN facilities, to assess the program integrity and provide guidance as indicated.

(4) Ensuring that VISN peer review summary data is collected, analyzed, and acted upon, as appropriate, and when significant variance is noted, each facility has a process in place to monitor until closure.

(5) Ensuring that quarterly VISN reports are submitted for review by Quality, Safety, and Value (QSV), as directed.

h. **VISN Chief Medical Officer.** The VISN Chief Medical Officer (CMO) is responsible for:

(1) Providing clinical leadership and direction for the implementation of this directive within assigned VA medical facilities, including community-based outpatient clinics (CBOC).

(2) Ensuring that facility outlier data is monitored and follow-up action communicated to the VISN Director and the VA medical facility Director, as appropriate.

(3) Working with the Chiefs of Staff and senior medical leaders to facilitate intra- and extra-VISN Peer Reviews for Quality Management external to the individual medical centers.

(4) Coordinating facility referrals for access to the national external Peer Review for Quality Management contract.

(5) Communicating clinical Peer Review for Quality Management priorities throughout VHA in coordination with the Deputy Under Secretary for Health for Operations and Management, Chief Medical Officers, Assistant Deputy Under Secretary for Health for Quality, Safety, and Value, and other program offices, as appropriate.

(6) Working collaboratively with the VISN Quality Management Officer, facility Quality Managers, and Risk Managers and/or Peer Review Coordinators to provide leadership and direction for the implementation of this directive.

(7) Coordinating peer reviews of care provided by a Chief of Staff to be assigned outside that Chief of Staff's facility. Providing any necessary feedback from the outside Peer Review Committee's findings to the Chief of Staff.

i. **VISN Quality Management Officer.** The VISN Quality Management Officer (QMO) is responsible for working collaboratively with the VISN CMO, facility Quality Managers, and Risk Managers/Peer Review Coordinators to provide leadership and direction for the implementation of this directive.

j. **VA Medical Facility Director.** The VA medical facility Director has ultimate responsibility for Peer Reviews for Quality Management that are performed within the facility. The VA medical facility Director is responsible for ensuring that:

(1) A Peer Review Committee (PRC) is established (see Appendix A).

(2) There is a credible process for assigning cases for peer review.

(3) A facility peer review process is developed that addresses, at a minimum:

(a) Specification of the participants to be involved in the Peer Review for Quality Management process, including incorporation of the definition of the term "peer" as defined in this directive.

(b) The individuals (by position) that are designated to be members of the PRC, what constitutes a quorum, and addresses the role of substitute members (e.g., whether they are allowed, voting rights, etc.).

(c) The voting method to be utilized by the PRC to determine Level of Care assignments.

(d) Method(s) for selecting ad hoc reviewers for Peer Reviews for Quality Management and the role of ad hoc members when participating in a PRC meeting are developed and followed consistently.

(e) There are timeframes for completion of Peer Review for Quality Management activities. This includes the timeframe for initiating the review, review by the PRC, and for reporting the results.

(f) The process for delineating review occurrences that are not appropriate for Peer Review for Quality Management, such as cases that are more appropriately addressed as management reviews, system issue reviews, or that come under the jurisdiction of law enforcement.

(g) Peer Reviews for Quality Management are individually designated as protected under 38 U.S.C. 5705 prior to initiation of the case review. The designation is the responsibility of the VA medical facility Director but can be delegated to the Chief of Staff. Designation memorandum should be signed within 3 business days of request and must be prior to the start of the review. See Appendix C.

(h) A reasonable opportunity for the individual(s) whose performance is being reviewed to provide input into the Peer Review for Quality Management process.

(i) There is a process for facilitating Peer Review for Quality Management outside of the facility. This process should include how to request a Peer Review for Quality Management within VHA or from the external contractor.

(j) There is a process utilized for data management and analysis of Peer Review for Quality Management data trends.

(4) Broad-based education on the Peer Review for Quality Management policy and processes is provided to:

(a) Physicians, nurses, and allied health care professionals who are likely to participate in Peer Review for Quality Management. This education is for a general understanding of the Peer Review for Quality Management process and responsibilities of professionals; it is recommended that this education take place on initial hiring or appointment to the facility. Training can be developed locally or the facility may use training materials made available by the VHA Risk Management Program.

(b) Peer reviewers and PRC members prior to participating in an initial Peer Review for Quality Management or serving on the committee. This education can be “just in time” and carried out by face-to-face instruction, web based modules, handouts, or other locally determined modalities. Training can be developed locally or the facility

may use training materials made available by the VHA Risk Management Program. The curriculum should cover the specific responsibilities of the reviewer and the PRC members during the Peer Review for Quality Management process and PRC deliberations.

NOTE: *Requirements for refresher training should meet local needs.*

(5) Peer Review for Quality Management is initiated when appropriate or required. It is appropriate only if it is intended solely for quality assurance purposes and the process is likely to yield information that will be useful from a quality and individual practice improvement perspective. There are selected serious clinical events that necessitate a Peer Review for Quality Management in all instances. In special circumstances, facility leadership may determine that a clinical event warrants an immediate non-protected review rather than initiating a Peer Review for Quality Management. For clinical events that require a Peer Review for Quality Management, see Appendix D. For clinical events that should be considered for Peer Review for Quality Management, see Appendix E.

(6) The facility may identify special clinical circumstances that necessitate Peer Review for Quality Management that is distinguished from those circumstances required in Appendix D. Additional considerations for required Peer Reviews for Quality Management may result from the mandatory screening of the following event sources:

(a) Mortality Review. Relevant episodes of care prior to any death, whether the death occurred within the VA medical facility or in the community setting, excluding Completed Suicides and Occurrence Screen 109 - Mortality during an inpatient hospitalization.

NOTE: *Expected deaths, such as those involving patients in hospice or palliative care, must be screened for potential Peer Review for Quality Management to improve care.*

(b) Major Morbidities. Major morbidities associated with clinical care including, but not limited to, operative (inpatient, outpatient, and same day surgery) and invasive procedures (e.g., chemotherapy, cardiac catheterization, interventional radiology, colonoscopy, and radiation therapy).

(c) Completed Suicide. See description in Appendix D and E.

(d) Attempted Suicide. See description in Appendix D and E.

(e) Unexpected or Negative Occurrence(s). Includes events when a patient has experienced a negative or unexpected outcome that may be related to the care.

(f) Executive Concern(s). Concerns about quality management issues from members of leadership and/or service and department chiefs; however, concerns that are likely to result in administrative action are not appropriate for peer review.

(g) Concerns of Other Facility Groups. Concerns of other facility groups are concerns from established organizational groups (e.g., Medical Records Committee, medical and surgical subspecialties) within the facility.

(h) Occurrence Screens. Cases meeting the following criteria, whether generated by the Veterans Health Information Systems and Technology Architecture (VistA) occurrence screen programs, a locally developed equivalent process, or identified in another way:

1. Readmission within 10 days of discharge following inpatient hospitalization (Screen 101.1).
2. Admission within 3 days following unscheduled Ambulatory Care visit (including Emergency Department) (Screen 102).
3. Return to OR in same admission (Screen 107).
4. Mortality during inpatient hospitalization (Screen 109).

NOTE: *Local equivalent procedures for data retrieval may be used as an alternative to the occurrence screen process.*

(i) Unscheduled return to the OR within 30 days of initial surgery or procedure.

(j) Patients converted to inpatient status from a same day surgery.

(k) Patients who require transfer for Emergency Department services or who are admitted directly following an outpatient procedure.

(l) Pre-payment Tort Claims. The VA medical facility may consider doing a Peer Review for Quality Management upon initial notification of the filing of a tort claim, if it would yield information that will be useful to the facility for quality assurance purposes. The Office of General Counsel may request a copy of a completed Peer Review for Quality Management as part of their document review, but it is not appropriate to do a Peer Review for Quality Management in anticipation of or at the request of the Office of General Counsel, or when another review modality (e.g., non-protected reviews, Management Review, or protected reviews, Root Cause Analysis (RCA), or Administrative Investigation may be more appropriate). However, a peer review at an early stage after the episode of care should not be precluded merely because there is a potential that a tort claim could be filed.

NOTE: *For this review to be protected by 38 U.S.C. 5705 and its implementing regulations, it must be directly related to improving the quality of health care delivered or the utilization of health care resources and not a Medical Advisory Opinion obtained solely for the purpose of assisting the United States in consideration of a tort claim settlement or defense of litigation under the Federal Tort Claims Act.*

(7) Quarterly, a de-identified summary report from the PRC discussing trends and analysis of aggregate data is reviewed by the Medical Executive Committee (MEC) and sent to the VISN for review. The peer review data summary must be submitted using

one of the reporting templates available on the Risk Management Intranet. The information submitted will include, at a minimum:

(a) The number of completed peer reviews, regardless of level, tracked and trended by final level of care assigned.

(b) The number of completed peer reviews by clinician type and/or service, as appropriate, with precautions taken to maintain clinical anonymity.

(c) The total number of initial peer review cases that were assigned a Level 2 or Level 3;

(d) The number and/or percentage of clinicians who were notified of initial Level 2 and/or Level 3 and were invited to submit written comments and/or participate in the peer review committee meeting;

(e) The number and/or percentage of notified clinicians who elected to submit written comments and/or participate in the peer review committee meeting;

(f) The number of levels assigned a higher level by the PRC (e.g., Level 1 to Level 2), or changed to a lower level (e.g., Level 3 to Level 2);

(g) The number of changes from one level to another tracked to identify relevant clinical trends;

(h) Tracking and trending the aspect of care for peer reviews that are determined to be a Level 2 or Level 3;

(i) Number of clinicians meeting locally designated Peer Review for Quality Management quality indicators;

(j) Timeliness of initial peer reviews tracked to identify relevant clinical trends;

(k) Timeliness of final peer review completion; and,

(l) Issues referred by the PRC to services for follow-up and their disposition, including identified system issues and actions completed (e.g., referral to another committee, such as Quality Management, Patient Safety, etc.).

NOTE: *VISNs and facilities may choose to require additional data elements to be reported at the end of the template.*

(8) There is a process for monitoring to closure (e.g., documented handoff to an entity that will review in a non-protected format) issues referred by the PRC for follow-up actions by Patient Safety, law enforcement, administrative investigations, or other appropriate venues. The final disposition does not need to be reported back to the PRC.

(9) Collaborating with the MEC (or equivalent), VA medical facility Chief of Staff, or, if appropriate, VISN CMO, to ensure follow-up actions are initiated for outlier data

findings that have been identified, and that interventions and outcomes are documented to closure.

(10) Requests for an extension beyond 120 days are reviewed and approved in writing.

(11) Ensuring that peer reviews of care provided by the Chief of Staff are conducted outside that Chief of Staff's facility. Upon completion of the initial review by the outside reviewer, the case will be presented to the outside facility's Peer Review Committee, as appropriate.

k. **Facility Chief of Staff.** Each facility Chief of Staff (COS) is responsible for providing clinical leadership and direction for the implementation of this directive, as well as complying with applicable confidentiality statutes and regulations within the facility. Specific responsibilities of the COS include:

(1) Chairing the PRC and clinical oversight of the Peer Review for Quality Management Program.

(2) Facilitating coordination of arrangements for initial reviews to be conducted at another facility or VISN when there is no qualified peer at the facility or if there is a conflict of interest to complete locally.

(3) Approving cases that are to be sent to the VISN CMO for referral for Peer Review for Quality Management under the national external peer review contract.

(4) Arranging for appropriate representation at PRC meetings when there is not a qualified peer available to serve (see Appendix A).

(5) Collaborating with the MEC (or equivalent), VA medical facility Director, or, if appropriate, VISN CMO, to ensure follow-up actions are initiated for outlier data findings that have been identified, and that interventions and outcomes are documented to closure.

NOTE: *The Medical Staff Bylaws must require medical staff member participation in the Peer Review for Quality Management process.*

l. **Medical Executive Committee.** The MEC is responsible for:

(1) Utilizing the data from the Peer Review Committee to determine the need for further action. Data and/or findings that may require further action by the MEC are:

(a) A low number of Peer Reviews for Quality Management.

(b) Overwhelming majority of Level 1 assignments.

(c) Absence of Level 3 assignments.

(d) Low participation numbers of providers with an initial Level 2 or Level 3.

(e) Consistent absence of changes of levels.

(f) Patterns of level changes (e.g., majority of final level assignments result in a decrease in the assigned level (i.e., Level 3 to Level 2 or Level 1)).

(g) System issues, as appropriate.

(2) Establishing occurrences that warrant local peer review in addition to those mandated by this directive.

(3) Establishing quality indicators (e.g., three Level 3 assignments to a clinician in a rolling 12-month period, or professional actions that may lead to a focused clinical care review). Quality indicators should be reviewed periodically and updated as needed to ensure that quality indicators are appropriate.

m. **Peer Review Committee.** See Appendix A and Appendix B.

n. **Service Chiefs and Program Directors.** Clinical service chiefs and program directors are responsible for:

(1) Ensuring their staff members are aware of the Peer Review for Quality Management process within their facility and its purpose.

(2) Ensuring that occurrences that may be considered for, or that require, Peer Review for Quality Management are identified and communicated to responsible program staff.

(3) Assisting in identifying, training, and mentoring peer reviewers as defined in this directive.

(4) Actively participating in the peer review committee when indicated.

(5) Providing feedback to medical trainees on Peer Review for Quality Management cases when they directly participated in the care.

(6) Initiating appropriate follow-up with staff for Peer Reviews for Quality Management that result in an assignment of Level 2 or Level 3 care.

(7) Participating in quality management activities to improve system issues identified during peer review.

o. **Peer Reviewer.** A Peer Reviewer must meet the following qualifications and be willing to accept the responsibilities listed:

(1) **Qualifications.** Each Peer Reviewer must:

(a) Possess the relevant clinical expertise necessary to make accurate evaluations about the decisions being reviewed.

(b) 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.

(2) **Responsibilities.** Each Peer Reviewer is responsible for:

(a) Withdrawing from participation in a case review if they had direct involvement with the care in question.

(b) Withdrawing from participation if it is determined that the specialized knowledge required exceeds their expertise or when they feel uncomfortable about judging the care.

(c) Withdrawing from review of cases where there is a conflict of interest or, for any other reason, the reviewer is unable to conduct an objective, impartial, accurate, and informed review.

(d) Maintaining privacy and confidentiality.

(e) Conducting a review of documentation. This includes:

1. Conducting each review based on evidence based guidelines as available, that were in place when the episode of care occurred. When necessary to support clinical determinations, analysis of peer reviewed, professional literature is appropriate.

2. Assigning a Level of Care (1, 2 or 3) to reflect the reviewer's evaluation of the standard of care given by an individual clinician.

3. If a level 2 or level 3 is assigned, one or more of the nine aspects of care (as listed in Appendix A, paragraph 3.b) must be annotated to support the level of care assigned, as well as any other information that supports the rationale for their decision.

4. Addressing any system issues identified.

(f) Notifying immediately, the facility COS, Associate Director for Patient Care Services/Nursing Service, or Service Chiefs and Program Directors, as appropriate, if the matter being reviewed raises concerns about the possibility of substandard care, negligence, or any other competency issue that might influence patient safety or professional privileges.

6. MANAGEMENT REVIEW

a. A management review is a non-protected review. A management review process must be used if the purpose is: to provide a basis for an action that may affect personnel status or clinical privileges; to be able to respond to an external inquiry (e.g., Office of the Inspector General or Government Accountability Office); or to provide a review for VA legal counsel in lieu of obtaining a Medical Advisory Opinion (MAO). If facility leadership determines that they need to have the discretion to undertake

administrative action following the review, the review must be initiated as a management review.

b. A management review must not occur concurrently with a Peer Review for Quality Management for the same episode of care. If the need for a management review can be anticipated, it is preferable to postpone the 38 U.S.C. 5705-protected activity until the management review is completed or cancel the protected activity. A Peer Review for Quality Management should be discontinued if the need for a Management Review is discovered after the Peer Review for Quality Management has begun. Only the summary of the occurrence or the event source can be communicated to a new reviewer in order to ensure there is a distinct separation of the protected and non-protected processes. The reviewer who conducted the Peer Review for Quality Management should not participate in the non-protected management review. This is to ensure that the confidentiality of the 38 U.S.C. 5705-protected activity is appropriately maintained and that the integrity of the process is preserved. All information gathered or used in relation to a management review, including use for any type of personnel action, must be obtained in a process that is independent of any 38 U.S.C. 5705-protected activity.

c. Management review activities, which are not protected by 38 U.S.C. 5705, include, but are not limited to:

(1) **Administrative Investigations.** An administrative investigation is an impartial inquiry, authorized by a medical facility Director or higher authority, to be conducted at any time deemed necessary to determine facts and collect evidence in connection with a matter of concern to VA. Administrative investigations compile factual information including conclusions, recommendations, and actions or decisions that may result in administrative actions (e.g., personnel or clinical privileging actions). Administrative Investigations can be a type of focused clinical care review that is generally authorized if conflicting information is gained through less formal channels of review and it is deemed necessary to place those being interviewed under oath to resolve conflicting statements (see VA Directive 0700).

(2) **Focused Clinical Care Review.** Focused clinical care review, also known as clinical care review, is a clinician-specific comprehensive clinical care review of a specific area of practice, a specific time period of practice, or both, when there is an identified concern or issue. This is a retrospective review of the clinician's practice used to determine what future steps, if any, will be taken, including a Focused Professional Practice Evaluation for cause or adverse privileging action. No further action may be taken if the concerns are not substantiated.

(3) **Focused Professional Practice Evaluations.** FPPE is not a restriction or limitation on the practitioner to independently practice, but rather an oversight process to be employed by the facility when a practitioner does not have the documented evidence of competent performance of the privileges requested. It is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility (see VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012).

(4) **Focused Professional Practice Evaluation for Cause.** An FPPE for cause is when a privileged Provider is given an “Opportunity to Improve” through a structured process. It is similar to a “Performance Improvement Plan” for non-privileged providers.

NOTE: *The terms “FPPE” and “FPPE for Cause” should not be used interchangeably – they are two very different processes and used for different purposes.*

(5) **Medical Advisory Opinions.** A medical advisory opinion is a review of an episode of care performed for the purpose of assisting the United States in consideration of tort claims or defenses of litigation under the Federal Tort Claims Act, done at the request of an attorney in the VA Office of General Counsel (OGC). The opinions are qualitatively different from a peer review and are to address, in detail, all the questions raised by the attorney representing VA. Medical issues not identified by the attorney, but the reviewer believes may be relevant to a decision on the claim also need to be addressed (see VHA Directive 2007-028).

NOTE: *Medical Advisory Opinions are generally protected from discovery in litigation or for trial by or for VA, or its agent or representative, including pursuant to Rule 26(b) 3, Federal Rules of Civil Procedure, if it was prepared in anticipation of litigation. Medical advisory opinions, in whole or in part, also may be protected under the Freedom of Information Act (5 U.S.C. 552). They are not considered confidential and privileged quality assurance records under 38 U.S.C. 5705 and are not to be disclosed without the approval of OGC or District Counsel.*

(6) **Ongoing Professional Practice Evaluations.** An ongoing professional practice evaluation (OPPE) is the ongoing monitoring of privileged clinicians to confirm the quality of care delivered and ensure patient safety. Activities such as direct observation, clinical discussions, and clinical pertinence reviews, if documented, can be incorporated into this process. Information and data considered must be clinician specific, and could become part of the practitioner’s provider profile analyzed in the facility’s defined on-going monitoring program (see VHA Handbook 1100.19).

(7) **Paid Malpractice Claim Reviews.** Malpractice payment reviews undertaken pursuant to 38 CFR Part 46, “Policy Regarding Participation in the National Practitioner Data Bank,” are not 38 U.S.C. 5705-protected reviews and are not included within the scope of this directive (see VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009).

7. REFERENCES

- a. 38 U.S.C. 5705.
- b. 38 U.S.C. 7301(b).
- c. 38 CFR 17.500-17.511.
- d. 45 CFR 164.512(d).
- e. VA Directive 0700, Administrative investigations.

f. VHA Directive 1026, VHA Enterprise Framework for Quality, Safety, and Value, dated August 2, 2013.

g. VHA Directive 1038, Role of the Office of the Medical Inspector, dated August 2, 2017.

h. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

i. VHA Directive 2008-077, Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents, dated November 7, 2008.

j. VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011.

k. VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009.

l. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.

PEER REVIEW COMMITTEE (PRC) AND THE PEER REVIEW PROCESS

1. COMPOSITION AND QUALIFICATIONS OF THE PEER REVIEW COMMITTEE (PRC)

a. The Peer Review Committee membership must:

(1) Be chaired by the Chief of Staff.

NOTE: *In the occasional absence of the Chief of Staff, a designee may be appointed.*

(2) Include the Associate Director, Patient Care Services (Nurse Executive).

NOTE: *A nursing representative cannot be permanently assigned to represent the Nurse Executive.*

(3) Be multi-disciplinary including, as appropriate, assigned or ad hoc members.

NOTE: *Senior Medical trainees, e.g., Chief Resident, may be assigned as a member of the PRC as part of their training assignment.*

(4) Consist of senior members, e.g., service chiefs, section chiefs of key clinical disciplines.

(5) Ensure representation by an individual capable of serving as a peer of the clinician whose case is being reviewed.

NOTE: *If there is not a member available for a case discussion in a peer review meeting that meets the criteria described, discussion of that case must be deferred.*

(6) The PRC is not required to include a peer of the same subspecialty as the individual being reviewed. The PRC may appoint an ad hoc member for discussion of a specialized case to ensure a fair and credible process is maintained.

b. The numbers of members that constitute a quorum must be at least a majority of voting members. No PRC member may have direct involvement with the episode of care under review.

c. The role and qualifications of ad hoc members must be established in a manner that ensures credible peer representation.

d. Substitute members replacing absent or excused permanent members are allowed on a temporary or interim basis (e.g., annual leave, position vacancy).

e. The PRC members must:

(1) Abstain from the discussion of any case when there is a conflict of interest or, for any other reason, the PRC member is unable to conduct an objective, impartial, accurate, and informed review.

(2) Complete initial and refresher peer review training as determined by local need.

2. PRC RESPONSIBILITIES

The PRC is responsible for:

a. Discussing all Peer Review for Quality Management cases within the facility completed by individual initial peer reviewers when the initial level assigned is determined to be a Level 2 or Level 3.

b. Providing evaluation and discussion of the initial review and the episode of care of a representative sample of Level 1 peer reviews. A sample of Level 1 peer review cases (at least 10 cases per quarter, or all Level 1s if less than 10) should be reviewed to ensure the validity and reliability of the peer review process. The PRC is to establish the process used to determine which Level 1 cases are referred for review, e.g., reviews of a given subspecialty for a quarter and/or specialty/sub-specialty cases infrequently seen by the PRC.

(1) If there are less than 10 initial Level 1 cases to be reviewed by the PRC per quarter, all initial Level 1 cases must be sent to the PRC.

(2) If there are 10 or more initial Level 1 cases to be reviewed by the PRC per quarter, at least 10 cases must be sent to the PRC.

c. Meeting on a regularly scheduled basis, at least quarterly.

NOTE: *The Chair may call ad hoc meetings, as needed.*

d. Reporting at least quarterly to the Medical Executive Committee (or equivalent) and other key leaders, as needed.

e. Coordinating the referral of significant clinical events to facility leadership.

NOTE: *Decisions regarding institutional disclosure are made by facility leadership and are not part of the Peer Review for Quality Management process.*

f. Completing the final review of each case within 120 days from the determination that a peer review is necessary. The exception for a delay, or an extension beyond 120 days, needs to be requested in writing, and approved by the VA medical facility Director.

g. Adhering to and monitoring compliance with timelines as follows:

(1) Screen for Need for Peer Review for Quality Management. The information that may require a Peer Review for Quality Management should be screened within 3 business days (excludes weekends and holidays) of its identification. A determination should be made at that time as to whether a Peer Review for Quality Management is appropriate.

(2) Timeline Starting Point. The timeline begins with the date that the designation memorandum was signed. This should be within 3 business days of request.

(3) Initial Review Completed. This should be completed within 45 calendar days from the date the determination the designation memorandum was signed.

(4) Final Review by Peer Review Committee Completed. This must be completed within 120 calendar days from the date the designation memorandum was signed.

h. Providing a final level assignment, in writing, for all cases brought before the PRC. The PRC provides recommendations for non-punitive, non-disciplinary actions to improve the quality of health care delivered or the utilization of health care resources. The supervisor of the individual who was reviewed is responsible for initiating appropriate action and follow-up.

(1) The supervisor of the individual(s) that was assigned a Level 2 or Level 3 will communicate with the individual(s) in their service and ensure that appropriate action is implemented.

(2) The supervisor must notify the PRC upon completion of the appropriate action and follow up.

i. Defining the facility process for the determination of a final level by the PRC (e.g., voting, consensus).

j. Reviewing external peer review audit outcomes as available, including consideration, documentation, and resolution of audits that may have two-level discrepancies between the external reviewer's level and the peer review committee's level.

k. Evaluating the supervision of health care profession trainees. Health care profession trainees, acting within the scope of their training program, are not independent clinicians and must be under the supervision of a Department of Veterans Affairs (VA) staff clinician.

(1) If the supervision of the trainee was deemed inappropriate, the Level of Care is assigned to the supervising clinician based on a suitability determination of the supervision provided to the trainee.

(2) If the supervision was deemed appropriate and the care provided by the trainee was determined to be below standards, a Level 1 is assigned to the supervising clinician for supervision; no level of care is assigned to the trainee. The PRC's concerns about the trainee are referred to the health care profession trainee's Chief of Service or Program Director for follow up, as appropriate.

(3) If there is evidence of gross negligence or willful professional misconduct on the part of the trainee, it must be reported to the trainee's Chief of Service or Program Director.

NOTE: *Peer Review for Quality Management findings may be shared with trainees, but in no case should the Level of Care be assigned to the trainee.*

l. Ensuring that formal discussions regarding a peer review occurring during PRC meetings are recorded in formal meeting minutes. Documentation relevant to any Peer Review for Quality Management must be maintained in a secure manner.

m. Notifying the clinician of the initial peer review level assignment of Level 2 or Level 3. The clinician should be invited to submit written comments or appear before the PRC prior to the committee's determination of a final level assignment. Clinician participation is to be documented in the PRC minutes. The clinician should be given a brief summary of the case and rationale for the level assignment; however, the actual peer review report should not be shared with the clinician. If the clinician has left VA service, the case should still be considered by the PRC if it is an initial level 2 or level 3, but the final level and any feedback are not required to be sent to the clinician. If the clinician has transferred to another VA facility, the clinician may be notified about the initial level and the opportunity to provide input to the PRC. If the PRC assigns a final level 2 or level 3, the clinician and the Chief of Staff at the new facility may be informed of the result as a means of improving practice.

(1) Reasonable efforts should be made to allow clinician participation by submission of a written statement, attending the meeting in person, or by teleconference.

(2) The initial peer review level as determined by the peer reviewer must not be modified prior to review by the PRC. Only the PRC has the authority to adopt or assign a different level to the peer review.

(3) The clinician may present a response on issues raised by the initial peer review. If the clinician declines to offer feedback to the committee, the PRC makes a final level assignment after case discussion.

(4) When the PRC reviews a case that was assigned Level 1 on initial peer review and determines the level needs to be changed to Level 2 or Level 3, the clinician is to receive an opportunity to respond to the PRC prior to finalizing the level assignment.

NOTE: *Since the peer review process for quality management is non-punitive, a formal appeal process following final level assignment by the PRC is not necessary or appropriate. However, only in special circumstances, the Chief of Staff may determine if requests for an additional discussion with the involved clinician will be granted. The outcome of this discussion should not result in the final level assignment being changed outside of the PRC.*

n. Providing periodic feedback, including mentoring, to initial peer reviewers on the reviews that they have completed. The PRC should develop an interrater reliability process to evaluate individual peer reviewers and the outcomes of their level assignments.

o. Documenting issues related to patient safety, law enforcement, or potential administrative investigations determined during the peer review process and referring those concerns to the appropriate management, professional, or law enforcement official in a timely manner.

p. Providing a quarterly roll-up of the de-identified data, data analysis, and recommendations to the Medical Executive Committee (or equivalent) for any necessary actions, to include data for review and analysis, as stated in 5j(7).

q. Managing documents, records and information related to the Peer Review for Quality Management program in a manner consistent with 38 U.S.C. 5705 and its implementing regulations.

r. The facility's Peer Review for Quality Management program must reference the designation by the Under Secretary for Health for Peer Review for Quality Management activity as protected under 38 U.S.C. 5705 and its implementing regulations.

(1) The following statement is recommended to be affixed to all documents generated by the Peer Review for Quality Management program: "The documents, records, and other information contained herein, which resulted from the Peer Review for Quality Management program are confidential and privileged under the provisions of 38 U.S.C. 5705, and its implementing regulations. This material cannot be disclosed to anyone without authorization as provided for by that law or its regulations. The statute provides for fines up to \$20,000 for unauthorized disclosures."

(2) All documents and information associated with Peer Review for Quality Management must be treated as strictly confidential and handled consistent with VA confidentiality and information security policies.

(3) De-identified data from Peer Reviews for Quality Management can be aggregated and communicated internally to the organized professional staff so that trends and opportunities for improvement are identified.

(4) The following records or documents, or parts thereof (among others) are not confidential under 38 U.S.C. 5705 (see 38 CFR 17.501(g)(2)):

(a) Statistical information regarding VA health care programs or activities that does not implicitly or explicitly identify individual VA patients or VA employees or individuals involved in the quality assurance process; described in 38 CFR 17.501(g) is not confidential under 38 U.S.C. 5705 if it does not implicitly or explicitly identify individual VA patients, employees, or individuals involved in the quality assurance process.

(b) Documents or records that only identify study topics, the period of time covered by the study, criteria, norms, and/or major overall findings, but which do not identify individual health care practitioners, even by implication.

NOTE: *Aggregated statistical information and/or summary documents remain protected if they can be used together with other information to implicitly identify individuals.*

(5) Staff responsible for the Peer Review for Quality Management program must work with the facility Privacy Officer and/or Freedom of Information Act (FOIA) Officer on any information requests from outside VA. They should also seek guidance as

needed to ensure that confidentiality within VA is maintained to the extent possible as permitted by 38 CFR 17.508, which addresses access within VA:

(a) VA employees (including consultants and contractors) who require access to protected information for the performance of their government duties and are authorized access by the VA medical facility Director, Veterans Integrated Service Network (VISN) Director, the Under Secretary for Health, or their designees, or by regulation, may be permitted access to 38 U.S.C. 5705-protected information.

(b) A clinician who is the subject of a Peer Review for Quality Management cannot be provided with a copy of the actual peer review document, even if redacted, to protect reviewer anonymity. A written summary of the relevant peer review findings and rationale for level assignment should be given to the clinician. Relevant clinical detail must be conveyed in a way that provides a complete and accurate picture of the reviewer's rationale and conclusions. This allows the clinician the opportunity to accurately address these issues if they choose to provide a response to the Peer Review Committee.

(c) A Peer Review for Quality Management record or document may be provided to any authorized staff member within these offices: Government Accountability Office (see 38 CFR 17.509); Office of General Counsel attorney; Department of Justice attorney when investigating a claim or potential claim against the VA or preparing for litigation involving the VA and the VA Office of Inspector General upon request (see 38 CFR 17.508); Office of the Medical Inspector, as a component of the Veterans Health Administration (VHA) is by VHA Directive 1038, Cooperation with the Office of the Medical Inspector, dated August 2, 2017.

(d) No individual shall be permitted access to confidential and privileged quality assurance records and documents unless such individual has been informed of the penalties for unauthorized disclosure. Any misuse of confidential and privileged quality assurance records or documents shall be reported to the appropriate VHA official (e.g., VA medical facility Director, Chief of Staff).

3. PEER REVIEW PROCESS

The Peer Review for Quality Management process consists of an initial review conducted by an individual peer reviewer followed by an evaluation and discussion of the initial review and the episode of care by the facility PRC. This review results in the determination of a Level 1, Level 2, or Level 3 provision of care as assessed against the nine Aspects of Care described below.

a. **Peer Review Levels.** The following are to be used in assessing the Level of Care decisions made by a clinician in peer reviews conducted by an individual peer reviewer, and in the evaluation and discussion of the initial review and the episode of care by the multi-disciplinary PRC.

(1) Level 1 is the Level at which experienced and competent clinicians would have managed the case in a similar manner.

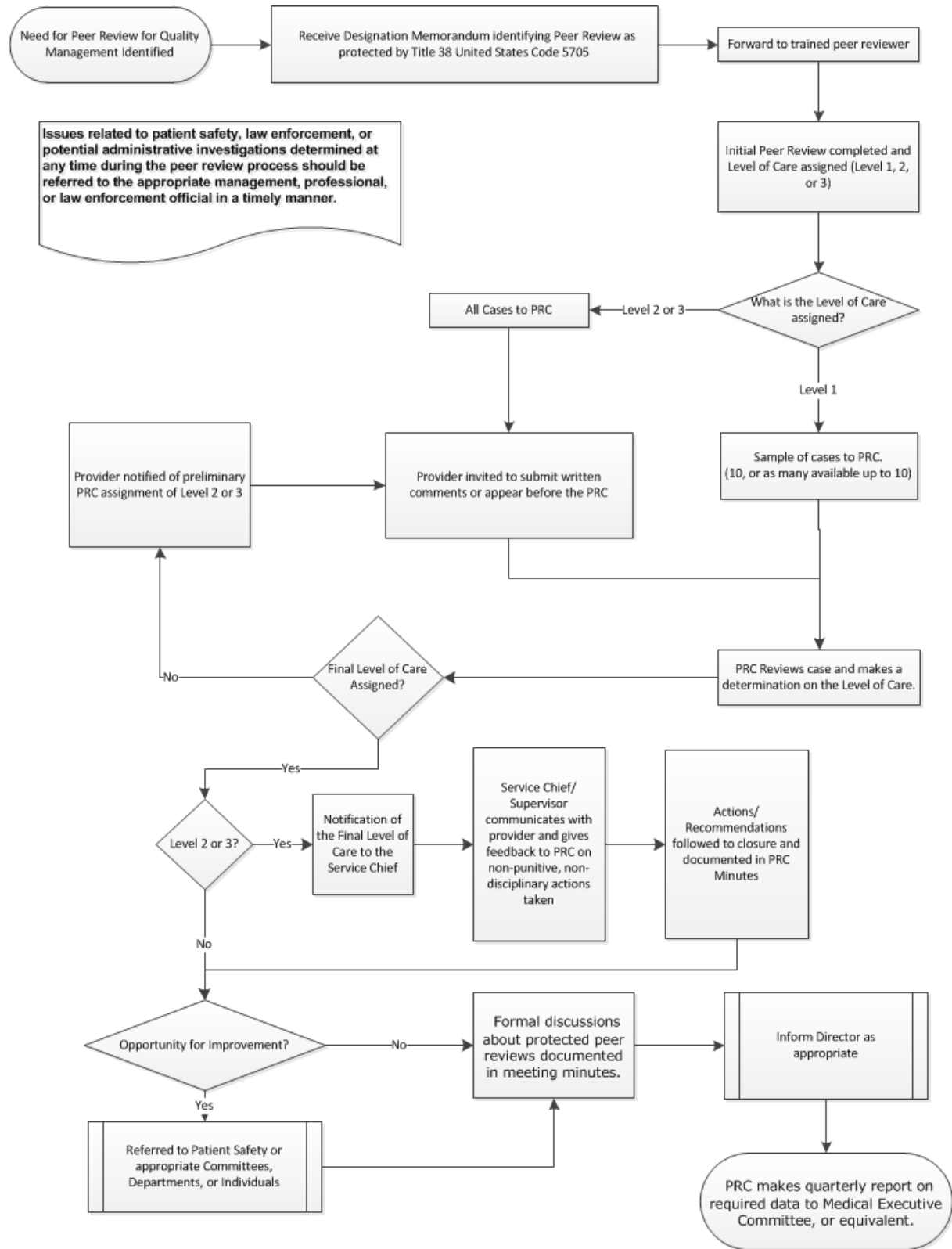
(2) Level 2 is the Level at which most experienced and competent clinicians might have managed the case differently but remains within the standard of care.

(3) Level 3 is the Level at which experienced and competent clinicians would have managed the case differently.

b. Nine Aspects of Care

- (1) Choice and/or timeliness in ordering of diagnostic tests.
- (2) Addressing abnormal results of diagnostic tests.
- (3) Timeliness of treatment initiation and/or appropriate treatment choice.
- (4) Performance of a procedure or treatment.
- (5) Timeliness and/or appropriateness of diagnosis.
- (6) Recognition and communication of critical clues to patient's clinical condition.
- (7) Timely initiation of appropriate actions during periods of clinical deterioration.
- (8) Health record documentation.
- (9) Supervision of health profession trainees.

PEER REVIEW FLOWMAP



November 21, 2018

VHA DIRECTIVE 1190(1)
APPENDIX C

**SAMPLE DESIGNATION MEMORANDUM FOR 38 UNITED STATES CODE 5705
PROTECTION**

**Department of
Veterans Affairs**

Memorandum

Date:

From: VA Medical Facility Director, or Designee; (Name) VA Health Care System

Subj: DESIGNATION MEMO - Quality Management Review Activity

To: Reviewer of case PR17-114

1. VA policy and regulations require that certain quality management review or quality assurance activities be "designated by the reviewing office at the outset of the review as protected" under 38 United States Code (U.S.C.) 5705 and its implementing regulations, 38 Code of Federal Regulations (CFR) 17.500 – 17.511.
2. In accordance with this regulation, I am directing you to conduct a peer review for quality management of case (example PR17-114) for the purpose of improving the quality of medical care and/or improving the utilization of health care resources.
3. This review and any documents created in the review process are protected under 38 U.S.C. 5705 and its implementing regulations; it is confidential and privileged information and may be used or disclosed only as permitted by the statute and regulations.
4. Should you require further information, please contact Name/Title at (contact phone number) or by Email at FirstName.LastName@va.gov.

VA Medical Facility Director or Designee

**CLINICAL EVENTS THAT REQUIRE A
PEER REVIEW FOR QUALITY MANAGEMENT**

1. Death that was preceded by a change in the patient's condition when there are questions regarding response to, management of, and/or communication related to the referenced change.
2. Death appears to be associated with a health care related incident, adverse event, or a complication of treatment.
3. Death within 24 hours of admission (except in cases when death is anticipated and clearly documented, such as transfer from hospice care).
4. Death within 48 hours of transfer out of a special care or intensive care unit (unless the transfer was made because death was anticipated).
5. Death during or within 30 days after a surgical or invasive procedure including same day surgery/diagnostic procedure unless the death is clearly not related to the surgery, or (if after 30 days) death is suspected to be related to the original procedure.
6. The circumstances of death appear to indicate there was a lack of appropriate palliative care.
7. Cardiac or pulmonary arrest that may have been preventable.
8. All suicides and attempted suicides by inpatients.
9. Completed outpatient suicide within 7 days after discharge from inpatient Mental Health treatment or residential care.
10. Attempted outpatient suicide within 3 days after discharge from inpatient Mental Health treatment or residential care.

**CLINICAL EVENTS THAT SHOULD BE CONSIDERED FOR
PEER REVIEW FOR QUALITY MANAGEMENT**

1. Unexpected transfer to a special care unit for complications, incomplete management prior to transfer, or premature discharge from the special care unit that resulted in transfer back to the unit.
2. Unplanned or partial removal, repair of organ or structure, or injury (laceration, perforation, tear, or puncture) during an invasive procedure.
3. Post-op complications on current admission or within 30 days of surgery.
4. Neurological deficit not present on admission.
5. Acute myocardial infarction or cerebral vascular accident within 48 hours following a surgical or invasive procedure.
6. Abnormal laboratory, imaging, or other test results not addressed by the responsible clinician.
7. Staff supervision not documented in the health record within 24 hours of patient admission.
8. Irregular discharges.
9. Non-completion of operative consent.
10. Patient and/or family issues and concerns that were unable to be resolved.
11. VA medical facility incurred patient incident, such as:
 - a. Falls.
 - b. Medication errors.
 - c. Patient injury other than fall.
12. Incomplete management in the Emergency Department (ED) or Urgent Care (UC), with or without a return for additional care.
13. Completed outpatient suicide over 7 days after discharge from inpatient Mental Health treatment or residential care, or never admitted for inpatient treatment or residential care.
14. Attempted outpatient suicide over 3 days after discharge from inpatient Mental Health treatment or residential care.