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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 an individual health care provider in VHA facilities. ***NOTE:** Not all peer reviews are for quality management; this Directive applies only to protected peer review activities completed for quality management purposes. Additionally, the terms “quality management,” “quality improvement,” and “quality assurance” are used interchangeably throughout this Directive.*

2. BACKGROUND

a. Peer review is a traditional organizational function designed to contribute to improving the quality of care and appropriate utilization of health care resources.

b. Peer review is defined as an organized process carried out by an individual health care professional or select committee of professionals, to evaluate the performance of other professionals. In the health care setting, peer review is applied to a broad array of activities of varying characteristics; this includes, but is not limited to: reviews done for Quality Management; Management Reviews, e.g., Administrative Investigation Boards (AIB); Clinical Practice reviews; Ongoing Professional Practice Evaluations (OPPE); Tort Claims; and National Practitioner Data Bank (NPDB) reporting.

c. Authority for Peer Review for Quality Management is found in Title 38 United States Code (U.S.C.) § 5705, entitled Confidentiality of Medical Quality-Assurance Records, and its implementing regulations Title 38 Code of Federal Regulations (CFR) §§ 17.500 through 17.511. In order for documents generated by a peer review to be protected under 38 U.S.C. § 5705 and its implementing regulations, the request for peer review must be designated in writing as being conducted or prepared for quality management or resource utilization purposes prior to its initiation. VHA peer review activities, in compliance with this Directive and current VHA policy, meet the requirements for a quality management document to be confidential and protected by 38 U.S.C. § 5705.

d. The requirements for a quality management document to be confidential are described in 38 CFR § 17.501 (a), (b), (c), and (g) of the confidentiality regulations. The document must meet one of the following conditions:

(1) Identifies, either implicitly or explicitly, individual providers or other employees, patients, or reviewers.

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(2) Contains discussions relating to the quality of VA patient care and the utilization of VA resources, e.g., length of patient stay as it relates to cost and quality by health care providers during a review of quality assurance data (see 38 CFR 17.501).

e. When conducted systematically and credibly, peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in the practice of one or multiple providers. This ultimately contributes to organizational improvements and optimal patient outcomes.

f. Peer review, as described in this Directive, is intended to promote confidential and non-punitive processes that consistently contribute to quality management efforts at the individual provider level. Although organization systems issues are sometimes identified, the primary goal is overall improvement in the care provided to Veterans through a review of individual provider decisions and actions. It is expected that peer review done for quality management fosters a responsive environment where issues are identified, acted upon proactively, and in ways that continually contribute to the best possible outcomes and strong organizational performance. Peer review encompasses multiple disciplines and requires active involvement from physicians, nurses, and other allied health care professionals who are required to exercise autonomous clinical judgment. **NOTE:** *Peer reviews for quality management cannot be used for personnel actions, such as: reassignment, changes in privileges, performance pay determinations, and disciplinary actions.*

g. VHA has utilized both individual and group approaches to peer review. Published evaluations of peer review processes highlight the benefit and justify consideration of alternative approaches in addition to the single reviewer approach. The use of a committee, subcommittee, or multiple reviewers with discussion to consensus to augment the peer review process is acceptable, as long as the requirements of this Directive are met.

h. The protected peer review process is to be consistent, timely, fair, comprehensive, useful, non-punitive, and balanced.

i. Different types of reviews (e.g., protected and non-protected) can occur before, concurrently, or after each other, as long as protected and non-protected information and processes are kept separate. **NOTE:** *When transitioning from a peer review for quality management to a management review process, only the initial report or summary of the occurrence can be communicated in order to ensure there is a distinct separation of the protected and non-protected processes.*

j. Reviews that are conducted, which are not confidential and privileged under 38 U.S.C. § 5705, and its implementing regulations, are not considered quality assurance activities and fall under the category of management reviews. If the facility staff determine that they need to have the discretion to undertake administrative action following a clinical review, a management review needs to be initiated. These management review processes, as well as any related documentation, are not protected by 38 U.S.C. § 5705, and its implementing regulations. The fact that documents generated from management review findings are, and can be, disclosed needs to be clearly understood and communicated (verbally and in writing) from the onset of a management review. Management reviews and other non-confidential reviews must, by law, be kept separate from any protected reviews.

k. Non-protected management review activities include, but are not limited to:

(1) **Focused Professional Practice Evaluations (FPPE).** FPPE refers to an evaluation of privilege-specific competence of a practitioner or provider who does not have current documented evidence of competently performing requested privileges. FPPE occurs at the time of initial appointment and prior to granting new or additional privileges. FPPE may also be used when a question arises regarding a currently privileged practitioner or provider's ability to provide safe, high-quality patient care (see VHA Handbook 1100.19).

(2) **Administrative Investigations.** An administrative investigation is a review of activities performed for the purpose of determining whether administrative actions, e.g. personnel actions, need to be taken.

(3) **Medical Advisory Opinions.** A medical advisory opinion is a review of activities performed for the purpose of assisting the United States in consideration of tort claims or defenses of litigation under the Federal Tort Claims Act, particularly if the review, e.g., health record episode of care review, is done at the request of the Regional Counsel or the Assistant United States Attorney. *NOTE: Refer to subparagraph 2l(9) for an expanded definition of medical advisory opinions.*

(4) **Ongoing Professional Practice Evaluations (OPPE).** OPPE is the ongoing monitoring of privileged practitioners and providers 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 practitioner or provider specific, and could become part of the practitioner's provider profile analyzed in the facility's on-going monitoring (see VHA Handbook 1100.19).

(5) **Peer Recommendations.** Peer recommendations refer to information submitted by knowledgeable colleagues that is used for credentialing and privileging purposes.

NOTE: Malpractice payment reviews undertaken pursuant to 38 CFR Part 46, "Policy Regarding Participation in the National Practitioner Data Bank," are not included within the scope of this Directive (see VHA Handbook 1100.17).

1. Definitions

(1) **Confidential Documents.** The term "confidential documents" is defined as 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, improving the utilization of health care resources, and which identify either implicitly or explicitly, individual providers or other employees, patients, or reviewers. These documents are considered privileged under 38 U.S.C. § 5705, and its implementing regulations. *NOTE: Confidential documents may be released to the Office of Inspector General (OIG) or Office of the General Counsel (OGC) at their request. Regional Counsel attorneys and staff are OGC employees. VHA may provide all VHA information, including individually identifiable information to OGC and the OIG for any official purpose authorized by law. This includes individually identifiable health information for the purpose of health care oversight (see*

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45 CFR 164.512(d) and VHA Handbook 1605.01). 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.

(2) **Provider.** For purposes of this Directive, the term “provider” is defined as a health care professional who is authorized to deliver health care exercising autonomous clinical judgment and whose actions are subject to review. This includes, but is not limited to: physicians, osteopaths, nurses, and other allied health care professionals who are required to exercise autonomous clinical judgment. **NOTE:** *This Directive does not apply to health care profession trainees acting within the scope of their training program.*

(3) **Peer.** A peer is a health care professional who has comparable education, training, experience, licensure, or similar clinical privileges or scope of practice.

(4) **Peer Reviewer.** The term “peer reviewer” is defined as a health care professional who can make a fair and credible assessment of the actions taken by the provider relative to the episode of care under review. Factors to consider when selecting a peer reviewer include, but are not limited to, whether the individual has similar or more advanced education, training, experience, licensure, clinical privileges, or scope of practice. Examples include: a general surgeon and a neurosurgeon performing the same procedure can peer review each other; an orthopedic surgeon can peer review a physician’s assistant assigned to the Orthopedic Clinic; a nurse practitioner working as a primary care provider can be peer reviewed by a physician who works in Primary Care.

(5) **Peer Review for Quality Management.** A Peer Review for Quality Management is a critical review of care performed by a peer or group of peers. All peer review processes must be in accordance with all applicable laws, regulations, current VHA policies, and this Directive.

(6) **Protected Peer Review**

(a) Essential elements of protected peer review include:

1. Peer evaluation of the care provided by individual providers within a selected episode of care.
2. Determination of the necessity of specific actions recommended by the peer review process.
3. Confidential communication back to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. This communication cannot include initiation of administrative actions, e.g., modification of clinical privileges.
4. Identification of systems and process issues that may require special consideration, investigation and possibly administrative action on the part of the facility staff.

(b) Language mandating protection of the peer review process under 38 U.S.C. § 5705, and its implementing regulations must be clear and incorporated into the facility policy. Language detailing the protection may be placed in the document as additional information (see subpar. 3l(6)(c)1.).

(c) All documents associated with peer review for quality management need to be treated as strictly confidential, unless determined otherwise after careful review (with documentation) by qualified VA personnel.

1. The following statement is recommended to be affixed to documents or forms that are designated as quality assurance documents:

“The documents, records, and other information contained herein, which resulted from ___(name of specific quality program or resource utilization activity)___, 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. A peer review conducted as part of a facility’s quality management program may not be disclosed outside of the quality management process. For example, a peer review for quality management may be initiated when a tort (malpractice) claim is filed, and will be a protected peer review so long as the purpose of the review is to identify, evaluate, and, where appropriate, correct circumstances having the potential to adversely effect the delivery of care. *NOTE: As long as confidentiality is maintained consistent with 38 U.S.C § 5705 and appropriately documented, data from peer reviews for quality management can be aggregated and communicated to the organized professional staff so that trends are understood and opportunities for improvement identified.*

3. Title 38 U.S.C. § 5705 protection does not mean that all documents are confidential. Aggregated statistical information that does not implicitly or explicitly identify individual VA patients, providers, employees, or peer reviewers involved in quality assurance processes, is not protected and may be disclosed. Similarly, summary documents which only identify study topics, the period of time covered by the study, criteria, norms, or general overall findings are not protected.

4. Aggregated peer review reports in which an individual provider cannot be identified can be shared and need to be communicated solely for the purposes of promoting organizational performance (including appropriate resource utilization) and optimal patient outcomes.

5. Providers who have been peer reviewed are to be notified of the outcome of the peer review and, as appropriate, provided with a verbal or written summary of the relevant peer review findings and rationale for level assignment. The provider is not to be provided with a copy of the actual peer review that was completed for the episode of care under review.

(7) **Peer Review Levels.** The following peer review levels are to be used in assessing the Level of Care decisions made by a provider in peer reviews conducted by an individual peer

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reviewer, as well as subsequent review by the multi-disciplinary Peer Review Committee (PRC).

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

(b) Level 2 is the Level at which the most experienced, competent practitioners might have managed the case differently.

(c) Level 3 is the Level at which the most experienced, competent practitioners would have managed the case differently.

(8) **Management Reviews.** A Management Review is any review that is conducted for purposes other than confidential quality improvement related to decisions affecting individual providers. Management Reviews are not protected; examples that fall under this classification are: Administrative Investigation Boards and Ongoing Professional Practice Evaluations.

(9) **Medical Advisory Opinions.** Medical Advisory Opinions refer to a review of an episode of care that is obtained to assist the OGC or Regional Counsel's decision to settle or deny a tort claim alleging medical malpractice. The opinions are qualitatively different from a peer review and are to address, in detail, all the questions raised by OGC or Regional Counsel. Medical issues not identified by the OGC or Regional Counsel, but which the reviewer believes may be relevant to a decision on the claim also need to be addressed. ***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 Regional Counsel.*

(10) **External Peer Review Contract.** Recent audits of clinical peer review conducted internally by the VHA staff have identified opportunities for improving the peer review process. VHA has retained the services of a national Contractor with expertise in conducting clinical peer review across all provider 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 is used for three types of reviews:

(a) Audit Reviews. Audit reviews are a secondary review of a sample of episodes of care that have undergone internal clinical peer review.

(b) Facility-requested Reviews. A facility-requested review 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.

(c) Triggered Reviews. Certain circumstances, such as outlier status on specific measures of clinical performance, may trigger a review of one or more episodes of care by an external reviewer.

3. POLICY: It is VHA policy that each Veterans Integrated Service Network (VISN) and health care facility must establish and maintain a program of peer review for quality management purposes (including resource utilization) relevant to the care provided by individual health care providers, in support of clinical care programs and professional services; and must comply with the requirements of those accrediting and oversight agencies that periodically review VHA health care facilities, including, but not limited to The Joint Commission.

4. ACTION

a. **Associate Deputy Under Secretary for Health for Quality and Safety (10G)**. The Associate Deputy Under Secretary for Health for Quality and Safety is responsible for:

(1) 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, the Principal Deputy Under Secretary for Health, the Chief Patient Care Services Officer, and other program offices, as appropriate.

b. **Chief Quality and Performance Officer (10Q)**. The Chief Quality and Performance Officer is responsible for:

(1) Providing an analysis of data findings, submitted by the VISNs, related to peer review for quality management.

(2) Reporting of data analysis findings to the Under Secretary for Health on peer review program activity within VHA.

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

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

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

(1) Establishing and maintaining the Peer Review for Quality Management Program in coordination with the Associate Deputy Under Secretary for Health for Quality and Safety (10G).

(2) Establishing performance targets for the medical centers related to peer review for quality

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management requirements, as appropriate.

(3) Providing direction and identification of data elements that are to be forwarded from facilities through VISNs to the Office of Quality and Performance (OQP).

d. **VISN Director.** Each VISN Director is responsible for:

(1) Ensuring that implementation of this Directive occurs within all medical centers and community-based outpatient clinics (CBOCs) within the VISN.

(2) Establishing oversight processes for peer review for quality management activities within the VISNs, in order to ensure that their facilities:

(a) Develop local policies consistent with this Directive,

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

(c) 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, in order 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 to the VHA Support Service Center (VSSC) Peer Review Reporting Application website at:

<http://vssc.med.va.gov/PeerReview/Login.aspx?ReturnUrl=%2fPeerReview%2fPeerReviews%2fManageReviews.aspx>, for review by the Deputy Under Secretary for Health for Operations and Management and the OQP, as directed.

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

(1) Providing clinical leadership and direction for the implementation of this Directive within all medical centers and CBOCs.

(2) Ensuring that facility outlier data is monitored and follow-up action communicated to the VISN Director and the 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 (see subpar. 2l(10)).

f. **VISN Quality Management Officer (QMO)**. The VISN QMO is responsible for working collaboratively with the VISN CMO and facility Quality Managers to provide leadership and direction for the implementation of this Directive.

g. **Facility Director**. The Facility Director has ultimate responsibility for peer reviews for quality management that are performed within the facility. The Facility Director is responsible for ensuring that:

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

(2) A facility peer review policy is developed that addresses, at a minimum:

(a) Specification of the participants to be involved in the peer review 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 and what constitutes a quorum. The role of substitute members (e.g., whether or not they are allowed, voting rights, etc.) needs to be addressed.

(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.

(e) Timeframes for completion of peer review for quality management activities, including when reviews are to be conducted and when results are to be reported to all parties concerned, including the providers whose care is under review, and as appropriate, leadership. Timeline begins with the date that the determination of need for peer review for quality management is identified. If the local review is untimely, the timeline begins with the date it should have been identified. The timelines that must be monitored are:

1. **Screen for Need for Peer Review for Quality Management**. This should be completed within 3 business days (excludes weekends and holidays) of identification or discovery of the event.

2. **Initial Review Completed**. This should be completed within 45 calendar days from determination of the need for the review.

3. **Final Review Completed**. This must be completed within 120 calendar days from determination of the need for the review

(f) A process for transfer of issues identified during the peer review process that would be more appropriately reviewed under the purview of patient safety, law enforcement, or an administrative investigation. The referral to the appropriate management, professional, or law enforcement official must be documented and completed in a manner that is consistent with relevant VA policy.

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(g) An opportunity for the individual(s) whose performance is being reviewed to fairly participate in the peer review process.

(h) The process for requesting an outside peer review for quality management when needed.

(i) A process for education of peer reviewers, PRC members, and health care professionals whose activities will be peer reviewed, as appropriate.

(j) The process utilized for data management and analysis of peer review trends.

(3) Broad-based education on the peer review for quality management policy and processes is provided to:

(a) Physicians, nurses, and other allied health care professionals who are required to exercise autonomous clinical judgment and are thus likely to participate in peer review. This education is for a general understanding of the peer review process and responsibilities of professionals; it is recommended that this education take place on initial hiring or appointment to the facility. Methodology can be decided locally and there is no required national training module. All current facility staff members are grandfathered in to this requirement as of May 1, 2010.

(b) Peer reviewers and PRC members prior to participating in an initial peer review or serving on the committee. *NOTE: Requirements for refresher training is to be need based and established in local policy.* This education can be “just in time” and carried out by face-to-face instruction, web based modules, handouts, or other locally determined modalities. The curriculum needs to cover the specific responsibilities of the practitioner during the peer review process and PRC deliberations.

(4) An Initial Peer Review is initiated when appropriate or required.

(5) The facility peer review policy specifies the circumstances under which the reviews need to be considered or required, including, but not limited to:

(a) Mortality Review. All deaths occurring within the medical center and those occurring in the community setting that are brought to the attention of the medical center and have identified concerns (including all suicides) must be screened against death review criteria (see Att. A). *NOTE: Cases that meet the criteria must be referred for peer review for quality management.*

NOTE: The diagnosis of a “terminal” illness, the existence of an advance directive, or a Do Not Resuscitate status are not considered exceptions from Peer Review for Quality Management.

(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, endoscopy, and radiation therapy.

(c) Suicides. Suicides within 30 days of any clinical encounter with a VA health care provider. **NOTE:** *Suicide attempts within 30 days of any clinical encounter do not require a mandatory peer review; however, they must be assessed to determine if a peer review needs to be initiated. This includes telephone encounters, telemedicine, etc.*

(d) Unexpected or Negative Occurrences. Unexpected or negative occurrences include events in which a patient has experienced a negative or unexpected outcome that may be related to the care provided and for which facility management considers peer review the best method for determining if the care was appropriate.

(e) Executive Concerns. Executive concerns are concerns about quality management issues from members of leadership or service and department chiefs that may initiate a request for a peer review when specifically related to the provision of patient care by a provider under the charge of the executive.

(f) Concerns of Other Facility Groups. Concerns of other facility groups are concerns from established organizational groups within the facility, which may submit a request for peer review for quality management purposes.

(g) Occurrence Screens. The following Veterans Health Information and Technology Architecture (VistA) occurrence screen programs (or a locally developed equivalent process) are used to gather and track comparable data:

1. Readmission within 10 days of discharge following inpatient hospitalization (Screen 101.0).
2. Admission within 3 days following unscheduled Ambulatory Care visit (including Emergency Department) (Screen 102).
3. Unplanned or unscheduled return to the operating room in same admission (Screen 107) (include patients converted to inpatient status from a same day surgery or outpatient procedure).
4. Mortality during inpatient hospitalization (Screen 109) (include patient deaths associated with same day surgery or outpatient procedures).

(h) Pre-payment Tort Claims. Initial notification of the filing of a tort claim may generate an immediate peer review for quality management. OGC or Regional Counsel can request a copy of a completed peer review for quality management as part of their document review; however, the completed peer review maintains its 38 U.S.C. § 5705 protection. **NOTE:** *For this review to be protected by 38 U.S. C. § 5705 and its implementing regulations, it must be directly related to 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.*

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(6) Quarterly, a summary of the PRC's analysis is reviewed by the Medical Executive Committee and sent the VISN for review. The peer review data summary is to include, at a minimum:

- (a) The number of peer reviews;
- (b) The number of deaths screened;
- (c) The assigned levels by the initial reviewer and the PRC; and

(d) The number of assignments of levels moved to a higher level by the PRC, e.g., Level 1 to Level 2, or moved to a lower level, and the delinquency rate for the timeliness of reviews.

NOTE: VISNs may choose to require additional data elements be reported.

(7) There is a process for monitoring to closure issues identified or referred by the PRC for follow-up by Patient Safety, law enforcement, administrative investigations, or other appropriate venues.

(8) Requests for an extension beyond 120 days must be reviewed.

h. **Facility Chief of Staff (COS)**. Each facility COS is responsible for providing clinical leadership and direction for the implementation of this Directive, as well as being in compliance with applicable confidentiality statutes and regulations within the facility. Specific responsibilities of the COS include, but are not limited to:

(1) Chairing the Peer Review Committee and clinical oversight of the Peer Review Program.

(2) Reviewing requests submitted by initial peer reviewers for extensions in the established peer review completion timeline.

(3) Facilitating coordination of arrangements for peer reviews to be conducted at another facility or VISN when there is no peer at the facility qualified to serve as a Peer Reviewer.

(4) Approving cases that are to be sent to the VISN CMO for referral for peer review under the national external peer review contract.

(5) Making arrangements for appropriate representation at PRC meetings when there is not a qualified "peer" available to serve (see Att. D).

(6) Determining, in cooperation with other VHA officials as appropriate, the need for, and completion of, clinical or institutional disclosure of information obtained through the peer review process. *NOTE: Decisions regarding clinical and institutional disclosure need to be made separately from the peer review process, but can be reported in the PRC.*

(7) Collaborating with the Medical Executive Committee (or equivalent), Facility Director,

VISN CMO, or VISN Director, as appropriate, 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 organized medical staff needs to participate in the peer review for quality management process and this participation is to be required in the medical center Medical Staff bylaws.*

i. **Peer Reviewer.** A peer reviewer must meet the following qualifications and be willing to accept the responsibilities listed in subparagraph 4i(2):

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

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

(b) Be able to make a fair and credible assessment of the actions taken by a provider 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. *NOTE: The facility Director needs to consider assigning an experienced peer reviewer as a mentor to an individual for the first few times a person is assigned to complete a peer review.*

(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) Abstaining from review of cases in which 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 confidentiality.

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

1. Reference the Levels of Care as listed in subparagraphs 2l(7)(a)-(c) to assign the standard of care given by an individual provider.

2. Use the eleven aspects of care listed in Attachment D subparagraphs 3a-3k, to evaluate quality and resource issues related to the care given by an individual provider.

3. Conduct each review through application of current standards of care and based on

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accepted evidence based practice guidelines (as available). When necessary to support clinical determinations, analysis of peer reviewed professional literature is encouraged.

4. The review should address any system issues identified as well as any other information that supports the rationale for their decision.

(f) Completing the initial peer review for quality management with Level of Care assignment must be timely and consistent with medical center policy. On the rare occasion when the initial peer review cannot be completed within the established time frame, a written extension must be submitted to the COS prior to the due date.

(g) Notifying, immediately, the COS, Associate Director for Patient/Nursing Service, or other Executives, as appropriate, if the matter being reviewed raises concerns about the possibility of substandard care, negligence, or any other competency issue that might impact patient safety or professional privileges.

j. **Medical Executive Committee (MEC)**. The MEC is responsible for:

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

(a) A low number of peer reviews.

(b) Overwhelming majority of Level 1 assignments.

(c) Absence of Level 3 assignments.

(d) Consistent absence of changes of levels.

(e) Unusual 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).

(f) Systems issues, as appropriate.

(2) Establishing peer review or professional activity triggers, e.g., three Level 3 assignments to a provider in a rolling 12-month period, or professional actions that lead to a focused review of a provider's clinical care.

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

(1) Ensuring that their staff are aware of the peer review process within their facility and its purpose.

(2) Ensuring that incidents and concerns that are appropriate for peer review are identified and communicated so that peer review consideration is initiated.

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

(4) Actively participating in the peer review committee as appropriate.

(5) Providing feedback as appropriate to medical trainees on cases in which they directly participated in the care that was brought to the Peer Review Committee.

(6) Initiating appropriate action and follow-up with staff for peer reviews that result in an assignment of Level 2 or Level 3 care.

(7) Participating in quality management activities to improve systems issues identified during the course of peer review.

5. REFERENCES

a. Title 38 U.S.C. § 5705, Confidentiality of Medical Quality Assurance Records.

b. Title 38 CFR 17.500-17.511, "Confidentiality of Healthcare Quality Assurance Review Records."

c. VHA Handbook 1050.1.

d. VHA Directive 0700.

e. VHA Handbook 1100.19.

f. VHA Record Control Schedule 10-1.

g. VA System of Records, 24VA136.

h. VHA Handbook 1907.01.

6. FOLLOW-UP RESPONSIBILITY: The Office of the Deputy Under Secretary for Health for Quality and Safety (10G) is responsible for the contents of this Directive. Questions may be referred to the Director, Risk Management Program, at (202) 266-4527.

7. RECISSIONS: VHA Directive 2008-004, dated January 28, 2008, is rescinded. This VHA Directive expires June 30, 2015.

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Under Secretary for Health

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ATTACHMENT A

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

If any of the following criteria are present, a peer review for quality management is required.

1. Lack of adequate documentation of patient's deterioration during 48 hours preceding death.
2. Change in patient's condition with no, or inadequate, action taken during 48 hours preceding death.
3. Cardiac or pulmonary arrest that could have been avoided.
4. Lack of concordance between patient's pre-mortem and post-mortem diagnoses.
5. Signs of patient's deteriorating condition that should have been noted and/or communicated to the physician, but were not.
6. Death appears to be related to a failure to carry out orders.
7. Lack of documentation indicating explanation for the death.
8. Lack of documentation indicating that the patient's death was expected.
9. Death appears to be related to a hospital-incurred incident or a complication of treatment.
10. Death within 24 hours of admission (except in cases in which death is anticipated and clearly documented, such as transfer from hospice care).
11. Death within 72 hours of transfer out of a special care unit (unless the transfer was made because death was anticipated).
12. Death during or within 30 days of a surgical procedure or (if after 30 days) death is suspected to be related to the original procedure.
13. Death appears to be related to a medication error or a choice of medication.
14. Death appears to be associated with a lack of appropriate palliative care.
15. Reason to think death may have been preventable.
16. Suicide within 30 days of a clinical encounter with a VA health care professional.

ATTACHMENT B

PEER REVIEW FOR QUALITY MANAGEMENT FLOWCHART



Peer Review for
Quality Management

ATTACHMENT C

SAMPLE OF POSSIBLE OCCURRENCE SCREENS

1. GENERAL OCCURRENCE SCREENS

a. Admissions for adverse results, complications, and incomplete management or problems during a previous hospitalization, (within 10 days).

b. Unexpected transfer to a special care unit for complications, incomplete management prior to transfer, or premature discharge from the special care which resulted in transfer back to the unit.

c. Unplanned or partial removal, repair of organ or structure, or injury (laceration, perforation, tear or puncture) during an invasive procedure.

d. Unplanned return to surgery on current admission.

e. Cardiac arrest.

f. Post-op complications on current admission or within 30 days of surgery.

g. Neurological deficit not present on admission.

h. Acute Myocardial Infarction or Cerebral Vascular Accident within 48 hours of a surgical or invasive procedure.

i. Abnormal laboratory, x-ray, or other test result not addressed by a physician.

j. Staff supervision not documented in the health record within 24 hours of patient admission.

k. Irregular discharges.

l. Non-completion of operative consent.

m. Patient and/or family issues and concerns that cannot be resolved.

n. Hospital incurred patient incident, such as:

(1) Falls.

(2) Medication errors.

(3) Alleged patient abuse.

(4) Suicide attempts and suicide.

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- (5) Assaults.
- (6) Missing patients.
- (7) Patient injury other than fall.
- (8) Death-unexpected or in conjunction with surgery.

2. AMBULATORY CARE OCCURRENCE SCREENS (in addition to the general occurrence screens).

- a. Admission within 3 days for adverse results, complications, or incomplete management of an ambulatory care visit.
- b. Subsequent visit to the Emergency Department (ED) or Triage for adverse results, incomplete management, or complications of previous hospitalization, out-patient care, and/or Nursing Home Care (NHC).
- c. Incomplete management in the ED or Acute Care (AC), during a visit.
- d. Inadequate documentation in the outpatient record.

ATTACHMENT D

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.

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

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

NOTE: 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 of key clinical disciplines.

(5) Ensure representation by an individual capable of serving as a “peer” of the provider 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.*

b. The PRC is not required to include a peer of the same subspecialty as the individual being reviewed. However, the PRC needs to seek outside consultation, e.g., inclusion of an ad hoc member for discussion of complex aspects of a specialized case, when needed to ensure a fair and credible process is maintained.

c. The number of members that constitute a quorum must be defined in the medical center policy.

d. No PRC member may have direct involvement with the episode of care under review.

e. The role and qualifications of ad hoc members must be defined in local policy.

f. The role and qualifications of substitutes replacing absent/excused members must be defined in the local policy as well as whether substitution is allowed.

g. The PRC members must:

(1) Withdraw from a case if it is determined that the specialized knowledge required exceeds their expertise or when they feel uncomfortable about judging the care.

(2) Abstain from a review of any case in which 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.

(3) Complete initial and refresher peer review training as defined in local policy

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2. PRC Responsibilities. The PRC is responsible for:

a. Reconsidering all peer review for quality management cases within the facility completed by individual initial peer reviewers when the level of review is determined to be a Level 2 or Level 3.

b. Providing secondary review of a representative sample of Level 1 peer reviews. A sufficient and representative sample of Level 1 peer review cases (at least 10 per quarter or 15 percent, whichever is greater, or all Level 1s if less than ten) need to be reviewed to ensure the validity and reliability of the findings and to evaluate the peer review process itself. The PRC is to establish the process that is used to determine which Level 1 cases are referred for review, e.g., focused reviews of a given subspecialty for a quarter; specialty or sub-specialty cases infrequently seen by 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 information to appropriate leadership due to a systems issue(s) and follow-up, as appropriate.

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 facility Director.

g. Providing a final level assignment, in writing, for all cases brought before the PRC. The PRC provides recommendations for non-punitive, non-disciplinary actions, as appropriate, 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) It is expected that 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 non-disciplinary, non-punitive action is implemented.

(2) Feedback of action taken must be accomplished by the supervisor's notification to the Peer Review Committee upon completion of the action.

h. Defining in facility policy the process for the determination of a final level by the PRC, e.g., voting, consensus, etc.

i. Evaluating the care provided by health care profession trainees. Health care profession trainees acting within the scope of their training program, are not independent practitioners, and must be under the supervision of a VA staff provider.

(1) If the case is assigned a Level 2 or Level 3 and the supervision was deemed appropriate, a Level of Care is still assigned, but will not be assigned to either the trainee or supervising practitioner. The PRC documents the Level of Care without assignment. In this case, the peer review is referred to the health care profession trainee's Chief of Service or Program Director, as appropriate.

(2) If the supervision was deemed inappropriate, the Level of Care is assigned to the supervising practitioner.

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

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 unless there is clear cut evidence of gross negligence or willful professional misconduct.

j. Ensuring that formal discussions regarding a peer review (e.g., occurring during peer review committee meetings) are recorded in formal meeting minutes. Documentation relevant to any peer review for quality management must be kept by a PRC official in a folder(s) that is not identifiable by provider; the folder must be stored in a secure location.

k. Inviting the provider whose care has received an initial peer review assignment of Level 2 or Level 3, to submit written comments or appear before the PRC prior to the committee's determination of a final level assignment. The provider should present any additional substantive documentation on issues raised during the initial peer review process to the PRC. This participation is to be documented in the PRC minutes. 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 provider is to receive an opportunity to submit written comments or appear before 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 required. However, the local facility may determine if requests for an additional meeting(s) with an involved provider will be granted in special circumstances.

l. Providing periodic feedback, including mentoring, to initial peer reviewers on the reviews that they have completed.

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

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n. Providing a quarterly roll-up of the data, data analysis, and recommendations to the Medical Executive Committee (or equivalent) for any necessary actions, to include recommended data elements for review and analysis, such as:

(1) The number of completed peer reviews and number of deaths referred to peer review tracked and trended by the provider under review, patient identifier, level of care, and service.

(2) The number of initial peer reviews not in compliance with the timelines defined in the local facility policy, tracked and trended by service.

(3) The number of changes from one level to another tracked and trended by service.

(4) Tracking and trending the aspect of care for those peer reviews for quality management that are determined to be a Level 2 or Level 3.

(5) Systems issues identified and actions (e.g., referral to another committee, such as Quality Management, Patient Safety, etc.) completed.

(6) Tracking of actions completed by service.

(7) Tracking and trending of cases not completed within 120 days.

3. Peer Review Process. The peer review process consists of an initial review conducted by an individual clinical peer reviewer followed by a secondary review by the facility PRC. **NOTE:** *A Morbidity and Mortality Committee at the service level may serve as the initial peer review; however, for full compliance with this Directive to be met, an independent review and level assignment by an individual who did not have direct involvement with the episode of care discussed must be completed. Other medical staff committees responsible for peer review, such as Blood Usage, Pharmacy and Therapeutics, or Operative and Invasive Procedure Review Committee may also use this process when full compliance with the requirements of this Directive are met.* This review results in the determination of a Level 1, Level 2, or Level 3 provision of care (see subpar. 2l(7) of the Directive) as assessed against the following Eleven Aspects for Review of Care:

a. **Peer Review Levels.** The following are to be used in assessing the Level of Care decisions made by a provider in peer reviews conducted by an individual peer reviewer, as well as subsequent review by the multi-disciplinary Peer Review Committee (PRC).

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

(2) Level 2 is the Level at which the most experienced, competent practitioners might have managed the case differently.

(3) Level 3 is the Level at which the most experienced, competent practitioners would have managed the case differently.

b. Eleven Aspects for Review of Care

- (1) Choice of diagnostic tests and timely ordering of those diagnostic tests.
- (2) Performance of a procedure or treatment.
- (3) Addressing abnormal results of diagnostic tests.
- (4) Timeliness of diagnosis and appropriateness of diagnosis.
- (5) Timing of treatment initiation and appropriateness of treatment.
- (6) Adequacy of technique during procedures.
- (7) Recognition and communication of critical clues to patient's condition during the period of clinical deterioration.
- (8) Timely initiation of appropriate actions during periods of clinical deterioration.
- (9) Health record documentation.
- (10) Supervision of health profession trainees.
- (11) Other relevant aspects of care.