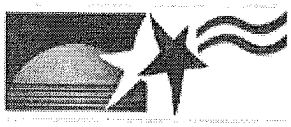
VA GREATER LOS ANGELES
HEALTHCARE SYSTEM



A Division of VA Desert Pacific Healthcare Network

BYLAWS AND RULES

OF THE

MEDICAL STAFF 2011

Adopted on

March 25, 2011

TABLE OF CONTENTS

BYLAWS

RULES

BYLAWS OF THE MEDICAL STAFF

PREAMBLE

The VA Greater Los Angeles Healthcare System (VAGLAHS) is organized under the general policies of the Department of Veterans Affairs (DVA) and the Veterans Health Administration (VHA). The Mission of the VAGLAHS is to honor America's veterans by providing exceptional healthcare that improves their health and well-being. Our Vision is to be a veteran-centered, integrated healthcare organization providing excellent healthcare, research, and education; an organization where people choose to work; an active community partner; and to provide assistance during National emergencies. Our Values include Trust, Respect, Excellence, Commitment, and Compassion.
Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and is accountable to the Governing Body of the organization for all aspects of that care, the Medical Staff of the VAGLAHS organizes itself for self governance in conformity with the laws, regulations and policies governing the DVA/VHA. The Medical Staff complies with Federal and State laws and regulations relating to such care to the fullest extent possible and consistent with regulations and policies of the DVA/VHA.
The Bylaws and Rules articulate how the Medical Staff is organized to meet these requirements. These Bylaws and Rules are not intended to create rights or liabilities not otherwise provided for in law or DVA/VHA Regulations. While these Bylaws and Rules attempt to make reference to the most current regulations and policies, it is the intention of these Bylaws and Rules to be in conformance with the relevant regulations and policies even if these change in between revisions of these Bylaws and Rules.

DEFINITIONS

1. **Medical Staff**: All physicians, dentists, podiatrists, optometrists, and psychologists that are privileged to attend patients, engage in medical education, and clinical research in the VAGLAHS (see categories of Medical Staff, Article V).

2. **Director**: The individual appointed by the Secretary of Veterans Affairs to act as the Governing Body in the overall management of the VAGLAHS within Federal law and VA regulation.

3. **Chief of Staff (COS):** The COS has the delegated responsibility from the VAGLAHS Governing Body (the Director) for the oversight of the professional and clinical competency of the Medical Staff within VAGLAHS. The COS is the leader of the Medical Staff.

4. **Dean's Committees**: Committees established by a formal memorandum of affiliation between GLA and affiliated medical, dental and other health professional schools. Membership is recommended by the Deans, UCLA Schools of Medicine and Dentistry and Deans, USC Schools of Medicine and Dentistry and approved by the Director. It is composed of Deans and senior faculty members of the affiliated medical

and dental schools and other academic institutions as appropriate; representative(s) of the medical and dental staff faculty; and such other faculty of the affiliated schools and staff of the facility (including the Nurse Executive) as are appropriate to consider and advise on the development, management and evaluation of all patient care, educational and research programs conducted at the VAGLAHS.

5. **Practitioner**: An appropriately licensed provider of healthcare.

6. **Medical Executive Committee (MEC)**: The Executive Committee of the Medical Staff. The Professional Standards Board acts as the Credentials Sub-Committee of the MEC (See Article VIII, Sections 3 and 4).

Article I. NAME

The name of this organization shall be the Medical Staff of the VA Greater Los Angeles Healthcare System (VAGLAHS).

Article II. PURPOSES

The purposes of this organization are:

1. To ensure that all patients treated in any of the facilities or services of the VAGLAHS shall receive the best possible care.

2. To ensure a high standard of professional performance of all practitioners authorized to practice in the VAGLAHS through the appropriate delineation of clinical privileges and through ongoing review and evaluation of each practitioner's professional performance in the VAGLAHS.

3. To provide an appropriate and effective setting that will ensure the continuous advancement of education and research.

4. To affirm the institutional commitment of VAGLAHS to Graduate Medical Education (GME), medical student education, Allied Health education, and continuing medical education that is supported by the governing authority, the administration, and the teaching staff.

5. To provide a means for the discussion and exchange of information between the Director and the Medical Staff on issues of mutual interest and importance.

6. To promote public trust and respect for the VAGLAHS through effective self-governance and a commitment to the highest standards of responsibility and accountability. This includes a commitment to meeting or exceeding the standards of external accrediting organizations.

Article III. MEDICAL STAFF MEMBERSHIP

Section 1. NATURE OF MEDICAL STAFF MEMBERSHIP

A. Medical staff membership is governed by these Bylaws and Rules. These Bylaws and Rules articulate a core set of rules and regulations that must be followed by paid and unpaid members of the medical staff. It must be understood that VA employment for medical staff members may entail additional responsibilities that are governed by the rules and regulations of Title 38 and are not listed here.

B. Medical Staff members shall:

(1) Be a citizen of the United States, or a non-citizen who is eligible according to criteria outlined in DVA/VHA regulations.

(2) Hold a degree of Doctor of Medicine, Osteopathy, Chiropractice, Dentistry, Optometry, or Podiatry or a doctorate in Psychology from an approved college or university.

(3) Have a current unrestricted license to practice his/her profession in one of the states or territories of the United States or the District of Columbia. A temporary license will be considered only if it is limited in duration, is limited as to the number of permitted renewals, and is issued because the practitioner has not completed a required period of residence in the State or has not yet obtained United States citizenship. The licensure requirement may be waived in accordance with VA regulations as outlined in the current VA regulations if the appointment is to an academic or research position where there is no involvement in patient care.

(4) Document information outlined in Article V, Section 1,C, including background, education, experience, training, health status related to requested clinical privileges, current competence and adherence to the ethics of their profession with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the VAGLAHS will be given high quality medical care.

C. Medical Staff membership is based on professional qualifications and criteria without regard for gender, age, sexual orientation, race, creed, religion, color, or national origin. The Equal Employment Opportunity (EEO) office is responsible for assuring compliance with this provision.

Section 2. ETHICS AND ETHICAL RELATIONSHIPS

A. Ethical standards for conflict of interest issues, including the acceptance of gifts, and the requirement for financial disclosure for the Executive Branch of the Government are set in 5 CFR § 2635. Additional ethical standards of conduct regarding relationships between VHA staff and pharmaceutical industry representatives are set forth in VHA Directive 2003-060. Acceptance of membership on the Medical Staff shall

constitute the staff member's certification that (s)he has in the past, and her/his agreement that (s)he will, in the future, strictly abide by the principles of legal ethics set forth in 5 CFR § 2635. Regional Counsel is responsible for assuring compliance with this standard.

B. Medical Staff members are expected to adhere to the ethical standards of their respective professional organizations, such as the American Medical Association, American Osteopathic Association, American Dental Association, American Optometric Association, American Podiatric Medical Association, American Psychological Association, and federal and state codes that are applicable to the appropriate discipline.

C. DVA/VHA Medical Staff members may not render professional service for remuneration to any patient hospitalized or treated at DVA/VHA expense in a non-DVA/VHA hospital, clinic, or other health care facility. Medical Staff who engage in outside professional activities for remuneration must scrupulously avoid creating any situation or circumstance where it might be implied that the Medical Staff member, because of his/her outside activity, is not meeting full requirements and responsibilities of his/her DVA/VHA position. Members of the Medical Staff will not serve in the capacity of a compensated expert witness in cases involving VA patients. All Title 38 staff members who engage in outside professional activities for remuneration shall meet the requirements of VA Handbook 2005.

D. Medical Staff who engage in peer review as a designated function will not participate in legal proceedings regarding cases that they have reviewed except as required by law.

E. Medical Staff members are required to respect the privacy and confidentiality of protected health information, as required by the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and VHA Handbook 1605.1.

F. The Medical Staff will adhere to all relevant VHA and GLA policies regarding compliance with business practices, research ethics and compliance and biomedical ethics. Acceptance of membership on the Medical Staff shall constitute the staff member's certification that (s)he will abide by the principles of ethics and integrity within these areas.

Section 2a. Code of Conduct

1. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being on duty as scheduled. (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving

preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

2. Disruptive Behavior and Inappropriate Behavior: VA recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. VA strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact.

   Disruptive behavior is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, disruptive behavior may reach a threshold such that it constitutes grounds for further inquiry by the Medical Executive Committee into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action.

   VA distinguishes disruptive behavior from constructive criticism that is offered in a professional manner with the aim of improving patient care. VA also reminds its providers of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a provider's health and performance. Providers suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing disruptive behavior on the part of other providers. VA urges its providers to support their hospital, practice, or other healthcare organization in their efforts to identify and manage disruptive behavior, by taking a role in this process when appropriate.

3. Professional Misconduct: Behavior by a professional that creates the appearance of a violation of ethical standards or has compromised ethical standards will not be tolerated.

Section 3. CONDITIONS OF APPOINTMENT

A. Appointments to the Medical Staff shall be made by the Director upon recommendation of the Medical Executive Committee (MEC).

B. All Medical Staff members, paid or unpaid except contract, must also have a GLA appointment to work within a GLA facility. Members of the Medical Staff paid through a contract will be members only during the period of the contract. Appointments to VA are made under the authority and provisions of 38 USC in accordance with relevant Handbooks.

C. Medical Staff membership shall confer upon the appointee only those clinical privileges requested by the individual, recommended by the GLA Department Chair or his/her designee, the MEC and the Chief of Staff, and approved by the Director.

Section 4: CATEGORIES OF THE MEDICAL STAFF

A. CATEGORIES

Medical Staff membership in the VAGLAHS will include active, associate, and didactic categories. Residents are not members of the Medical Staff but are supervised by the Medical Staff as described in the Rules.

B. ACADEMIC APPOINTMENTS

It is the intent of the Medical Staff that all members of the Active Medical Staff must be eligible for academic appointment and shall obtain this appointment as soon as possible, except for site-specific and profession-specific considerations, which may preclude this. Those individuals whose position requires an academic appointment in order to perform their duties are responsible for working through the Department Chairs and Chief of Staff for obtaining and maintaining these appointments.

C. ACTIVE MEDICAL STAFF

The active Medical Staff shall consist of all full time and part time physicians, dentists, podiatrists, optometrists, and psychologists who are professionally responsible for specific patient care, education, and/or research activities of the VAGLAHS.

Members of the active Medical Staff shall be appointed to a specific professional department, shall be eligible to vote, to serve on Medical Staff committees, and be required to attend Medical Staff meetings.

D. ASSOCIATE MEDICAL STAFF

The Associate Medical Staff shall consist of those duly appointed-fee basis, contract or Without Compensation (WOC) physicians, psychologists, optometrists, and podiatrists who are responsible for supplementing the practice of members of the active Medical Staff in their role in education, patient care, and/or research. Fee basis, contract staff, or staff appointed WOC shall not vote at or be required to attend meetings of the Medical Staff. They are required to have academic appointments if they participate in the supervision of trainees.

E. DIDACTIC OR TEACHING APPOINTMENTS

All practitioners in the disciplines represented on the medical staff who have clinical activities for the purpose of patient care, teaching, or research must be members of the medical staff with appropriate credentials and privileges. If the practitioner does not have any patient contact but is engaged in didactic teaching or research, that person is not required to be a member of the medical staff although s(he) must have approved credentials and an appropriate VA appointment.

Section 5. CLINICAL PRIVILEGES OF STAFF MEMBERSHIP

A. Each individual who holds clinical privileges shall:

(1) Provide care and supervision of his/her patients at a professionally recognized level of quality and efficiency, and with attention to maximizing patient satisfaction.

(2) Accept and discharge those staff, committee, teaching, discipline, care line, and VAGLAHS functions for which (s)he is made responsible by such methods as appointment or election.

(3) Prepare and complete, in a timely manner, the required clinical records of all patients for whom (s)he provides care at the VAGLAHS.

(4) Actively participate in peer review, patient safety, continuous quality improvement, utilization management, patient risk management, and other quality improvement activities required by professional standards as well as internal and external review bodies.

(5) Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies, and rules of the VAGLAHS.

ARTICLE IV. APPOINTMENT

Section 1. TERMS OF APPOINTMENT TO THE ACTIVE MEDICAL STAFF

A. Appointments to the Medical Staff occur in conjunction with VA employment or through a VA contract or sharing agreement. The Director shall make appointments to the Medical Staff, for a period not to exceed two years, after the recommendation of the Medical Executive Committee. Applicants shall request renewal of their VA appointments, if necessary, in conjunction with their request for renewal of clinical privileges and Medical Staff Membership every two years. Appointments to the Medical Staff shall confer upon the appointee only such privileges as may be granted by the Director.

B. The Director shall make initial appointments to the GLA Medical Staff after recommendation by the Chief of Staff. Initial employment appointments (i.e., as contrasted to transfers from another VA facility) are probationary, during which time evaluation of the applicant's performance and clinical competence, including data and other input from each venue, will be facilitated by the appropriate Department Chair and Chief of Staff. At the end of the probationary period, if the employee has demonstrated an acceptable level of performance, the probationary status may be converted to a career appointment in accordance with VHA regulations and policies.

Section 2. PROCEDURES FOR APPOINTMENT

A. All applicants for Medical Staff positions, including research staff whose duties include providing patient care and assessment, will be subject to the qualifications and appointment procedures in accordance with the regulations of the DVA/VHA, including the requirement to demonstrate English language proficiency.

B. Completed applications for appointment to the Medical Staff shall be submitted to the MEC through the Professional Standards Board (PSB) on prescribed electronic forms and paper forms that are signed by the applicant. The Chief of Staff has the responsibility of verifying the items submitted and checking references in keeping with applicable VA and Joint Commission guidelines. Applications shall outline in detail the clinical privileges that the applicant requests. Recommendations to approve appointment and grant privileges are made to the Director. The Director will approve or disapprove applications for appointments within 15 working days of receipt from the MEC.

C. Prior to appointment by the Director, applicants must submit the following to the Medical Staff office:

(1) Documentation of professional school graduation, residency training (if applicable), professional licensure and specialty board qualification (if applicable).

(2) A minimum of three references shall be obtained from the applicant, including one from the current or most recent employer or institution where

the applicant practiced or had privileges; for recent residency graduates one reference must be from the director of the relevant training program.

(3) A statement concerning any previously successful or currently pending challenges to any licensure, certification, or registration (state, district, or Federal, including the Drug Enforcement Administration) or voluntary relinquishment of such licensure or registration.

(4) Statement concerning all past or present liability claims or judgments.

(5) A statement concerning voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at a DVA/VHA or any other health care organization.

(6) A copy of the current (or the most recent) clinical privileges at the current or most recent health care facilities in which the applicant has been or is practicing his or her profession.

(7) A statement concerning previous voluntary or involuntary loss, suspension, or denial of professional licensure or professional society membership.

(8) A statement concerning any prior withdrawal of contracting rights with the Centers for Medicaid and Medicare Services (CMS), as documented on the Health and Human Services Sanctions List.

(9) A statement regarding the applicant's health status related to the ability to perform requested clinical privileges; all applicants, both initially and for renewal, must be physically and mentally capable of carrying out the required functions of their Medical Staff membership and the privileges which they are to be granted.

(10) A statement that (s)he has received and read the Bylaws and Rules of the Medical Staff and agrees to be bound by them as well as VAGLAHS policies and procedures that apply to his/her activities as a Medical Staff member.

(11) All members of the Medical Staff will be certified in Basic Life Support (BLS) by the American Heart Association. Clinical departments may require Advanced Cardiac Life Support (ACLS) certification for practitioners functioning in high acuity environments (for example, Emergency Department or Intensive Care Units). A waiver to the BLS requirement may be granted by the Chief of Staff when the member is unable to perform BLS and when the lack of certification would not endanger patients (i.e., the member only works in a practice setting with certified BLS staff).

D. The Professional Standards Board will recommend appointment and privileging actions to the MEC as outlined in VAGLAHS Policy on Professional Standards Board. The MEC will vote on the proposed appointment and privileging actions prior to their submission to the Director for final approval.

E. Emergency Credentialing in a Disaster Situation: Physicians, dentists and advanced-level practitioners (ALPs - physician Assistants, Nurse Practitioners and Certified Nurse Anesthetists) who do not possess clinical privileges or have approved Scopes of Practice at GLA may be extended emergency clinical privileges when the facility Emergency Management Plan has been activated. They should present to the credentialing coordinator or a designee of the Chief of Staff/Director who has knowledge of the credentialing process a valid U. S. license to practice within any of the states or territories of the United States or the District of Columbia, photo identification and the contact information of a hospital, clinic or group where they recently practiced. Verification of credentials and clearances will be done as soon as possible. Such appointments will be rescinded as determined by the Chief of Staff/Director when services are no longer needed. It is recommended that they work under the direct supervision of a medical staff member. During the emergency, there is no limit to the number of ALPs a supervising physician may supervise simultaneously.

ARTICLE V. CLINICAL PRIVILEGES

Section 1. DELINEATION OF CLINICAL PRIVILEGES

A. A member providing direct clinical service at the VAGLAHS shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Director. Said privileges must be within the scope of any license, certificate, or other legal credential authorizing him or her to practice, and consistent with any restrictions thereof. Clinical privileges are granted to an applicant based not only on the applicant's qualifications but also on consideration of the procedures and types of care or services that can be performed or provided within the VAGLAHS and at each specific setting within VAGLAHS. The original signed clinical privileges document, indicating privileges granted will be placed in the practitioner's Credentialing and Privileging Folder.

B. Professional oversight and facilitation of clinical privileging, reprivileging and competency evaluations for each member of the Medical Staff will be assigned to a GLA Department Chair or designee. Clinical privileges may be granted in more than one department.

C. Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.

D. Exercise of clinical privileges within any venue is subject to the expectations and rules of the venue management team, including the GLA Department Chair or designee, ensuring consistency with VHA standards and standards of practice within the medical community.

E. Credentialing and privileging will be conducted in accordance with VHA Handbook 1100.19, dated November 14, 2008. All department chiefs, section chiefs, members of the Professional Standards Board, and other members of the Medical Staff who review and recommend credentials and privileges will have completed the VHA Credentials and Privileges on-line training modules on the VHA Office of Quality and Performance intranet page.

F. Physicians who diagnose or treat patients through a telemedicine link must be credentialed and privileged in this activity according to VHA Handbook 1100.19, dated November 14, 2008. This handbook is on file in the Credentials and Privileging Office of the Chief of Staff.

Section 2. NEW APPOINTMENTS

A. Clinical privileges will be proposed by the Department Chair or designee with input from venue management based on a review of the applicant's education, training, experience, demonstrated ability and judgment, qualifications and competency to exercise such privileges. The completed credentials file will be forwarded in sequence for review and approval to the Professional Standards Board, the MEC, and the Director.

B. Three months following a new appointment, departments will perform a focused practice evaluation of the quality of care according to department defined evaluation criteria and will include this review in the quality of care file for that practitioner. (See also Section 5, Ongoing Professional Practice Evaluation)

C. When a member of the Medical Staff requests new privileges, there will be a focused practice evaluation after three months.

D. In the case of a practitioner with a low volume of clinical activity, the period of focused evaluation may be extended in order to have a sufficient number of cases for review.

Section 3. TEMPORARY PRIVILEGES

A. In the event of emergent or urgent patient care needs, temporary privileges not to exceed 45 working days may be granted by the Director upon recommendation by the COS. Such privileges will be based on documentation of a current State license and other reasonable, reliable information concerning training and current competence. In most cases, the appropriate department chair will advise the COS as to the need for temporary privileges and the qualifications of the practitioner being considered for these privileges.

B. Special requirements of supervision and reporting may be imposed by the appropriate Department Chair or designee on a practitioner granted temporary privileges The Director may at any time, upon recommendation of the Department Chair or designee, terminate a practitioner's temporary privileges. Such individuals are not entitled to a hearing or appeal.

C. Temporary privileges will not be granted to individuals with current or previously successful challenges to licensure or with involuntary terminations, denial or loss of privileges.

Section 4. RENEWAL OF CLINICAL PRIVILEGES

A. Clinical Privileges will be reviewed for renewal at intervals not to exceed two years. Following initial appointment, The applicant shall apply for reprivileging at the time of review. This application shall include updated information on:

(1) Desired changes in clinical privileges;

(2) Changes in health status that affect, or are likely to affect, ability to perform clinical duties;

(3) Continuing medical education and continuing education units received since the last privileges were granted;

(4) All current licenses or certificates, including current BLS or ACLS certification.

(5) All licenses that have expired or that are no longer held for any reason;

(6) Any disciplinary action by licensing boards or other professional sanctions (state, DEA, etc.);

(7) Changes to clinical privileges held at any other institution;

(8) Professional liability claims, including any final judgments or settlements;

(9) Any felony criminal charges;

(10) National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank query;

(11) Health and Human Services Sanctions List query;

(12) Quality improvement data obtained since the last review, including quantitative aggregation and analysis of the ongoing professional practice evaluation.

(13) Continuation of appropriate VAGLAHS appointment

B. Any significant changes in status of the items above are to be reported to the Chief of Staff through the appropriate Chair or Vice Chair at the time they occur.

C. Information regarding whether items (A.1) through (A.11) above have been, or are in the process of being denied, revoked, suspended, restricted, reduced, limited, placed on probation, not renewed, voluntarily or involuntarily relinquished or application withdrawn must be provided along with a full explanation.

D. Renewal of clinical privileges will be recommended by the Department Chair or Vice Chair. This action will be based on the evaluation of the staff member's professional performance, clinical judgment, technical skills and compliance with legal requirements and with the Medical Staff Bylaws and Rules. The Department Chair or designee will include the relevant findings of quality of care reviews and administrative reviews in the reprivileging process as well as the physical and mental health of the individual. Reprivileging will not be granted without the provision of practitioner specific quality management/performance improvement data.

E. The recommendations of the Department Chair or designee will be reviewed by the Professional Standards Board and forwarded to the MEC and the Director for review and approval.

F. Clinical privileges may be reviewed at any time, and may be suspended or revoked at any time for cause, such as loss of license or a lapse in renewal.

G. Failure on the practitioner's part without good cause to file a completed application for reappointment on a timely basis shall result in the automatic lapse of the member's admitting and other privileges and prerogatives at the end of the current Medical Staff appointment, unless otherwise extended by the Chief of Staff with the approval of the Director.

H. Medical staff members who are paid VA employees are subject to disciplinary action up to and including termination of VA employment in the event of a lapse in privileges.

Section 5. ONGOING PROFESSIONAL PRACTICE EVALUATION

A. Each department shall conduct an ongoing evaluation of each practitioner's performance according to a defined, evidence based department and discipline plan. The purpose of this evaluation is to assure that each member of the Medical Staff continues to exercise privileges at an acceptably high standard of care. The record of this evaluation shall be included in each practitioner's quality of care file and will be considered during the privilege renewal process.

B. This evaluation will be done according to the provisions of the VAGLAHS Policy on Ongoing and Focused Professional Practice Evaluation. OPPE will occur every six months for each professional member of the Medical Staff and will evaluate the six domains of professional competence including Patient Care, Medical/Clinical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and System-Based Practice. Each

departmental plan will include defined standards of proficiency and triggers for focused professional practice evaluation.

Section 6. DENIAL, REDUCTION OR REVOCATION OF CLINICAL PRIVILEGES

A. The initial privileging or reappraisal process may identify privilege requests that should not be granted based on the information available. Such concerns shall be discussed between the Chief of Staff, the Department Chair and the requesting individual. Examples of such issues, which result in reduced privileges, are documented unsatisfactory performance, failure to perform a sufficient number of operations and/or procedures to maintain proficiency, or failure to use privileges for high-risk procedures or treatments over a period of two years. Because clinical practice and clinical techniques change over time, it is normal that clinical privileges would also change. At the time privileges are requested, the Department Chair or designee shall review with the practitioner those specific activities, procedures and/or treatments that are being requested. If there is disagreement, the Medical Staff member shall attempt to resolve the matter with the COS.

B. Data gathered in conjunction with the facility's Quality Management program may be an important resource for identifying potential deficiencies. However, material, which is obtained as part of that program, may not be disclosed in the course of any action to reduce or revoke privileges, nor may any adverse action be based directly on such data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the Quality Management program, such as administrative reviews and boards of investigation. In these instances the Quality Management data may have triggered the review; however, the Performance Improvement information is confidential and privileged in accordance with Section 38 U.S.C. 5705, and must be rediscovered through the administrative review or investigation process.

C. Data gathered in conjunction with the OPPE and FPPE processes will be used expressly for determining whether members of the Medical Staff should continue to exercise privileges. Failure to meet acceptable standards of quality of care, as evidenced by a pattern of care or by one or more egregious lapses in the quality of care, may be grounds for reducing or revoking clinical privileges.

D. If it becomes necessary to formally reduce or revoke clinical privileges the following process must be followed and any adverse action coordinated with due process as outlined in VHA Handbook 1100.19, dated November 14, 2008.

(1) Prior to final action by the Director to reduce privileges, the affected Medical Staff member will be notified by the Chief of Staff of the proposed action. This notice will include a discussion of the reason(s) for the action, and a statement of the member's rights.

(2) The affected member may appeal the proposed action by responding in writing with a statement justifying the reason each privilege in question

should be granted. Response must be submitted to the Chief of Staff within ten (10) workdays of the action.

(3) All information regarding the proposed action including the response of the affected member and the written recommendation of the Chief of Staff will be forwarded to the Director for final decision. If the member disagrees with the Director's decision, he/she may request a hearing. Request for a hearing must be submitted in writing to the Director within five (5) workdays of receipt of the Director's written decision.

(4) In the event a hearing is requested, the Director will appoint a panel within five (5) workdays consisting of three professionals, two of whom will be members of the same profession as the affected Medical Staff member including at least one professional of the same specialty or subspecialty. During the hearing, the member has a right to a representative, the right to question witnesses, and an opportunity to purchase a copy of a transcribed tape of the hearing.

(5) Once appointed, the panel will complete the review within fifteen (15) workdays and submit findings and recommendations to the Director. The Director will issue a written decision within ten (10) working days after the date the panel's report is reviewed. The Medical Staff member may submit a written appeal to the appropriate Network Director within five (5) workdays of the receipt of the Director's decision. The decision of the Network Director is final.

E. If the Chief of Staff, in consultation with the department chief and with the concurrence of the Director, determines that the continued exercise of clinical privileges by a member of the Medical Staff may endanger the health, safety, and well-being of patients , the Chief of Staff has the authority to reassign the member to non-clinical duties for up to 30 days while appropriate investigations are made. This period of reassignment does not in itself represent a reduction or revocation of privileges. If at the end of the investigation it is determined that reduction or revocation of privileges is appropriate, the processes, timelines, and reporting requirements in this Section will commence.

F. If the Chief of Staff, in consultation with the department chief and with the concurrence of the Director, has reason to believe that a member of the Medical Staff is impaired by health issues, substance use, or for other reasons, the Chief of Staff has the authority to remove the member from patient care and other duties for up to 30 days while appropriate investigations are made. In consultation with Human Resources and other VA officials, the member will be referred to the Impaired Professional Program (GLA Policy 00-E1-22; VHA Directive 5383) or for a fitness for duty evaluation. This period of reassignment does not in itself represent a reduction or revocation of privileges. If it is determined that reduction or revocation of privileges is appropriate, the processes and timelines in this Section will commence. These provisions do not apply during a period the member is on leave due to illness.

G. If a member of the Medical Staff faces allegations of patient abuse or neglect or similar misconduct that requires the member to be removed from patient care while the allegations are investigated, the member will not be considered to have a reduction or revocation or privileges during the period of investigation. If a member of the medical staff is subject to adverse disciplinary action for professional or non-professional misconduct, privileges will be considered suspended during the period the member is suspended as an employee. Further action regarding privileges will follow the processes in paragraphs H and G above.

H. Members of the Medical Staff who fail to maintain an unrestricted license in at least one state or territory of the United States or the District of Columbia or who fail to reapply for renewal of privileges at VAGLAHS will be subject to automatic suspension of privileges and may be subject to administrative actions. If a member of the Medical Staff is terminated for cause, privileges will be revoked automatically and the member may be reported to state licensing boards following the processes in Section 7 below. If a member of the Medical Staff is terminated for administrative reasons (for example, budget considerations) it will not be considered reduction or revocation of privileges for reporting purposes.

I. In those cases in which revocation of all clinical privileges is recommended for a member of the Medical Staff, the proposed revocation must be combined with a request to terminate employment. This applies to both Title 5 and Title 38 employees.

Section 7. REPORTING OF PRACTITIONERS

A. All procedures will be in accordance with VHA Handbooks 1100.17, dated December 28, 2009 and 1100.18 dated December 22, 2005. The Department of Veterans Affairs is required to disclose information to State Licensing Boards and the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB) on the clinical professional practice of those current or separated practitioner where the individual has so significantly failed to conform to generally accepted standards as to raise reasonable concern for the safety of private sector patients. When a licensed member of the Medical Staff is terminated or leaves employment for any reason and there is serious concern about professional clinical competence, all available documentation will be referred to the Medical Inspectors Office (19) VA Headquarters with a request for approval to notify the appropriate State Licensing Board(s).

VA officials are not authorized to enter into any written or oral agreement that would prohibit or restrict the release of information to a State Licensing Board.

Section 8. PEER REVIEW

A. Peer Review at GLA will be carried out in accordance with GLA Policy 00-11-08, Peer Review Policy, and VHA Directive 2008-004 Peer Review for Quality Management. Peer review for purposes of improving quality of

care is confidential and protected under Section 38 USC 5705 and may not be used for any other administrative purpose, including decisions about privileges.

B. Staff members reviewing or providing information relative to credentialing, staff membership, and privileges of applicants are protected from civil liability under the Federal Tort Claim Act. Staff members who engage in peer review as a designated function will not participate in legal proceedings regarding cases that they have reviewed except as required by law.

C. Peer reviews will be conducted in response to an unexpected adverse outcome of a serious or potentially serious nature or in response to concerns expressed by patients or other members of the Medical Staff about the practice of a member of the staff. Clinical Departments will refer for Peer Review cases identified through department and discipline specific occurrence screens.

D. All members of the Medical Staff must receive general training on Protected Peer Review policy and processes at the time of appointment. All members of the Medical Staff who participate in peer review must receive specific training on performance of peer reviews. All members of the Peer Review Committee must have specific training on peer review when appointed to the committee and every two years thereafter. Training is defined in VHA Directive 2008-004, Peer Review for Quality Management, and is available through the VHA Office of Quality and Performance intranet site.

ARTICLE VI. ORGANIZATION OF THE MEDICAL STAFF

Section 1. OFFICERS

The only officer of the Medical Staff is the Chief of Staff. He or she is appointed by a process defined by VA regulations. The Department of Veterans Affairs has no provision for elected "officers" of the Medical Staff.

Section 2. LEADERSHIP

The Chief of Staff is the leader of the Medical Staff and serves as the Chair of the Medical Executive Committee.

Section 3. APPOINTMENT AND REMOVAL OF THE CHIEF OF STAFF

The Chief of Staff is appointed by the Director following a formal search for the best possible candidate, consistent with Equal Employment Opportunity requirements. The Chief of Staff will be accorded due process in removal proceedings. Actions to remove the Chief of Staff will be carried out for cause in accordance with applicable VA policy

and regulations. The Director is responsible for appropriate coordination and action when considering or processing a proposed removal of the Chief of Staff.

Section 4. ORGANIZATION

A. Clinical services are delivered in an interdisciplinary fashion under the leadership of site specific Lead Physicians, Department Chairs, Care Line Directors, Deputy and Associate Chiefs of Staff. Department Chairs for disciplines represented on the medical staff and Associate Chiefs of Staff report to the Chief of Staff. Appointments of the Chief of Staff, Deputy Chief of Staff, the Associate Chief of Staff for Research, the Associate Chief of Staff for Education, the Associate Chief of Staff for Ambulatory Care, the Associate Chief of Staff for Clinical Informatics, the Chief of Organizational and Performance Improvement, the Assistant Chief of Staff for Quality Assurance, the Department Chairs, and equivalent new positions shall be made according to VHA regulations. The Director will make these appointments with the advice and counsel of the Deans Committee.

B. Medical Staff will be assigned to appropriate Departments, Services, Care Lines and clinic sites subject to VAGLAHS needs and individual qualifications. Such qualifications shall be determined by the process for appointment outlined in Article V.

C. The Director, through the Chief of Staff, delegates to the Care Line Directors, Department Chairs, Deputy and Associate Chiefs of Staff the following:

(1) Accountability for clinical and administrative activities within their discipline.

(2) Provision of continuous quality improvement within their discipline, considering findings of ongoing monitoring and evaluation of quality; appropriateness of care and treatment provided to patients (including that provided under temporary or emergency privileges); patient satisfaction information; patient safety improvement/risk management activities; and utilization management.

(3) Participation in the development and implementation of policies and procedures to assure effective management, ethics, safety, communication, and provision of quality services within the discipline.

(4) Assessment and recommendations to the relevant VAGLAHS authority off-site sources for needed patient care services not provided by the discipline.

(5) Coordination and integration of interdisciplinary services related to the discipline.

(6) Recommending appropriate numbers of qualified and competent staff, space, and other resources for the provision of care or service in the discipline.

(7) Participating in the selection, orientation, evaluation, and training of all staff assigned to the discipline.

(8) Convening staff meetings at appropriate intervals to meet the needs of the discipline. Minutes and a record of attendance will be maintained in the office of the Care Line Director, Department Chair, or both, as appropriate.

(9) The Department Chair/Care Line Director/Associate Chief of Staff is not merely a consultant to senior management. The Department Chair/Care Line Director/Associate Chief of Staff has line authority and is accountable and responsible for all programs and activities within his/her department or care line. If patient care is unsafe, the Department Chair/Care Line Director/Associate Chief of Staff is responsible for taking action to fix the problem immediately. If the Department Chair or Care Line Director cannot resolve the problem promptly, he/she must notify the Chief of Staff. If additional staff or other resources are required, the issue will be considered immediately by the leadership team. If resources are unavailable and the situation cannot be corrected, the program must be reduced to a safe level that can be supported by existing resources. If necessary, the program may need to be temporarily closed down. No compromises to patient care or patient safety will be tolerated.

D. The Chief of Staff may delegate to staff serving in the capacity of Department Chairs the following:

(1) Monitoring the professional activities and standard of care delivered by professionals in that discipline.

(2) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department, including ensuring that they practice within their scope of privileges.

(3) Recommending to the Medical Staff the criteria for clinical privileges for members of their department.

(4) Recommending approval or otherwise of clinical privileges for each member of their department.

(5) Participating in the selection and assignment, orientation and continuing education of staff in their department.

(6) Convening departmental meetings to evaluate practices and policies, and to perform peer review and chart review activities, etc.

(7) Overseeing professional education programs.

(8) Mentoring staff on academic pursuits.

E. The Associate Chief of staff for Education has the delegated responsibility for educational activities throughout VAGLAHS pertaining to professional trainees and oversight of the Continuing Medical Education program.

F. The Associate Chief of Staff for Research has the delegated responsibility for the administration and conduct of all research activities throughout VAGLAHS.

G. All members of the Medical Staff will be responsible to their respective Care Line Directors or Department Chairs for their day-to-day clinical activities. They are responsible to the Department Chair to meet the standards of care for their profession, and they are responsible to the Chief of Staff, through their Department Chair, Care Line Director, or both, for their use of approved time for research, teaching, and other academic activities.

H. The quality of patient care will be evaluated by the Medical Staff. All members of the Medical Staff will participate in programs of continuing education to stay abreast of pertinent new developments in the diagnostic and therapeutic aspects of patient care related to their clinical privileges, and to refresh themselves in various aspects of their basic clinical education.

I. The Chief of Staff is responsible for the quality of clinical care by Members of the Medical Staff as it occurs across the lines of responsibility of the Associate Director and the Nurse Executive, and for the administration of all programs managed by Medical Staff members with the title Deputy Chief of Staff, Associate Chief of Staff or Assistant Chief of Staff. He or she is also responsible for administration of the Credentials and Privileging process for members of the Medical Staff.

ARTICLE VII. COMMITTEES

Section 1. STANDING COMMITTEES

A. Standing committees shall be appointed by the Director on recommendation by the Medical Executive Committee. All committees are charged with the duty of assuring that Medical Staff are in compliance with DVA/VHA and Joint Commission requirements applicable to their area of responsibility, including peer review. The purpose, function, membership and organization of specific committees are delineated by charters that are consistent with VHA/VAGLAHS Directives, Policies, standard operating procedures (SOPs), or memoranda.

B. Membership of committees will be delineated in the committee charters. The Chief of Staff will appoint members to the committees, including the committee chairs. Members will be appointed for two-year terms and may be reappointed. Members who do not participate in committee meetings and duties may be removed by the Chief of Staff upon the recommendation of the committee chair.

Section 2. COMMITTEE ORGANIZATION

A. Rules of Order: Committees will function according to the principles articulated in Sturgis Standard Code of Parliamentary Procedure unless alternative rules are approved by majority vote of the committee.

B. Quorum: A quorum will consist of a majority of the voting members of a committee. For example, the quorum for a nine (9)-member committee would be five (5) members. Once a quorum is established it shall remain in effect for the duration of the meeting.

C. Attendance: Committee members are expected to attend all standing committee meetings unless excused by the chair. Excused absences will be recognized for duly approved annual leave, duly approved authorized absences, sick leave, and for unexpected and urgent patient care.

D. Records: Each committee will maintain written minutes of meetings to include attendance and all transactions and recommendations. Each committee chair will assure that each recommendation is directed in a timely manner to the appropriate authority for consideration and possible implementation.

Section 3. MEDICAL EXECUTIVE COMMITTEE (MEC)

A. Purpose: The Medical Executive Committee will serve as the representative of the Medical Staff, and will direct and address all matters that affect medical care at the VAGLAHS. The MEC will receive and review reports and recommendations from the various Medical Staff committees, Department Chairs or Vice Chairs, or their designees, Care Line Directors and Associate Directors, and Associate Chiefs of Staff. The MEC will review and approve or disapprove proposed significant changes in the delivery of clinical care.

B. Membership: The Medical Executive Committee consists of the Chief of Staff as Chair, Deputy Chief of Staff, Associate Chief of Staff/Research, Associate Chief of Staff/Education, Assistant Chief of Staff for Quality Assurance, Chief of Organizational Performance and Improvement, Department Chairs, Medical Staff representatives who are required to be on the committee by approved accrediting organizations (such as the Director of the Cancer Center), Associate Chiefs of Staff for Ambulatory Care, Clinical Informatics, and Geriatrics, Care Line Directors, Lead Clinicians from the ambulatory care centers at West Los Angeles, Sepulveda, and Los Angeles, directors of other specified clinical centers (Director, Geriatrics Research, Education, and Clinical Center; Medical Director of the Nursing Home Care Unit; Telehealth Director) who are members of the Medical Staff, and the Chair of the Bylaws and Rules Committee. The Director and the Nurse Executive serve as ex officio members. There will be four additional members selected by the Chief of Staff to represent the medical staff at the West Los Angeles campus and associated CBOCs, the Sepulveda campus and associated CBOCs, the Northern CBOCs, and the Los Angeles Ambulatory Care Center and associated CBOCs. MEC members may designate an alternate, to be approved by the Chair, to attend MEC meetings in their stead when necessary. Alternates will have voting privileges.

C. The MEC will:

(1) Oversee the process and criteria for Medical Staff membership and clinical privileges.

(2) Oversee clinical committees and review and make recommendations based on these reports/minutes.

(3) Oversee and support all organizational performance improvement activities including clinical risk management and external review programs.

(4) Review contracts for providing clinical care, including the review of quality of care provided under these contracts.

(5) Oversee and assure compliance with the Bylaws and Rules of the Medical Staff

(6) Oversee the Medical Education and Research missions of the VAGLAHS.

(7) Make recommendations on planning and clinical service development and coordination.

(8) Review and act on recommendations from the Professional Standards Board.

D. The MEC will meet at least 10 times per year. Any member of the Medical Staff may attend the meetings, except the executive session, but may not vote on motions.

Section 4. PROFESSIONAL STANDARDS BOARD

The Professional Standards Board (PSB) is chaired by the COS or designee and functions as the credentialing sub-committee of the MEC. All applicants for appointment/reappointment and requests for privileges and reprivileging will be reviewed by the PSB. Credentials review will be accomplished in accordance with DVA/VHA rules and regulations and Joint Commission standards. The PSB will assure that there is one standard of care for clinical practice by reviewing and approving the actions of Professional Standard Boards that approve scopes of practice for licensed independent practitioners for disciplines that are not represented on the Medical Staff. Upon completion of this review, the PSB will submit each request to the MEC for review and action in confidential executive session. The PSB will review the FPPE and OPPE plans for each department or discipline. The PSB will review FPPE and OPPE data for members of the Medical Staff, Advanced Practice Nurses, Physician Assistants, and other licensed professionals working under Scopes of Practice.

Section 5. OTHER MEDICAL STAFF COMMITTEES

A. Transfusion Committee
B. Medical Records Review
C. Pharmacy and Therapeutics

D. Radiation Safety
E. Infection Control
F. Ethics Advisory Committee
G. Graduate Medical Education
H. Cancer Committee
I. Bylaws and Rules Committee
J. Peer Review Committee
K. Suicide, Violence, Disruptive Behavior Prevention Committee
L. Patient Safety Committee
M. Library Committee
N. Invasive Procedures Committee (IPC, a subcommittee of the Peer Review Committee)
O. Continuing Medical Education Committee
P. Nutrition Committee

Other Medical Staff Committees may be appointed at the discretion of the MEC.

Section 6. VAGLAHS-WIDE COMMITTEES WITH MEDICAL STAFF REPRESENTATION

A. Executive Leadership Board
B. Clinical Leadership Council
C. Patient Centered Care/Planetree Council
D. Strategic Planning Council
E. Innovations/Recognition Council
F. Organizational Improvement Council
G. Compliance Committee
H. Research & Development Committee
I. Resources Committee
J. Service Quality Council
K. Inpatient Operations Council
L. Ambulatory Care Council
M. Mental Health Council
N. Workforce Development Council

ARTICLE VIII. ANNUAL AND SPECIAL MEETINGS OF THE MEDICAL STAFF

Section 1. ANNUAL MEETING

The Chief of Staff will hold a general meeting of the Medical Staff as a whole at least once annually, known as "The Annual Meeting of the Medical Staff". The Chief of Staff shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. The Bylaws of the Medical Staff will be reviewed and approval of the Bylaws voted upon. Business transacted at the annual Medical Staff meeting shall be that stated in the Notice calling for the meeting, and

those matters petitioned for, in writing or electronically, by at least 20% of the active Medical Staff, at least 30 days prior to the Annual Meeting.

Section 2. SPECIAL MEETINGS

The Director or Chief of Staff may call special meetings of the Medical Staff at which no business shall be transacted other than that stated in the notice of the meeting.

Section 3. ATTENDANCE

A. Active Medical Staff members will attend the Annual Meeting and all Special Meetings of the Medical Staff unless specifically excused for appropriate reasons, e.g. illness, leave or clinical requirements. Active Members of the Medical Staff are voting members.

B. Associate Members of the Medical Staff may attend the Meetings of the Medical Staff, but their presence is optional and they are not considered members for voting or for the purpose of establishing a quorum.

Section 4. QUORUM

The presence of at least twenty-five percent of the voting Medical Staff Members at the annual or any special Medical Staff meeting shall constitute a quorum. Once a quorum is established it shall remain in effect for the duration of the meeting.

Section 5. MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. The meeting chair shall refrain from voting except when necessary to break a tie.

Section 6. MINUTES

Minutes shall be recorded and maintained in the Office of the COS for the Annual Meeting and all Special Meetings of the Medical Staff.

Section 7. NOTICE OF MEETINGS

Written notice stating the place, day, and hour of the annual or special Medical Staff meetings shall be delivered either to the director or department or by electronic mail to each person entitled to be present not fewer than 2 working days nor more than 45 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

ARTICLE IX. ADOPTION

These Bylaws will become effective upon the joint endorsement of the Chief of Staff and the Director of the VAGLAHS after approval by the Medical Staff by simple majority vote at the Annual Meeting.

ARTICLE X. AMENDMENTS

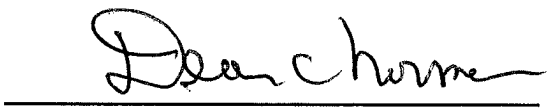
Amendments to the Bylaws may be proposed by any member of the Medical Staff. Amendments to the Bylaws may be proposed by two pathways. Amendments supported by petition (in writing or electronically) of at least 20% of the active Medical Staff, at least 30 days prior to the Annual Meeting, shall be submitted to the full membership of the Medical Staff for voting at the Annual Meeting. Proposed amendments may also be referred to the Bylaws and Rules Committee for review and subsequent submission to the MEC for approval or disapproval by majority vote. Amendments approved by the MEC will be submitted to the full membership of the Medical Staff for voting at the Annual Meeting or by electronic submission and voting between Annual Meetings. Amendments approved by a majority vote of the Medical Staff will become effective when approved by the Director.

ARTICLE XI REVIEW

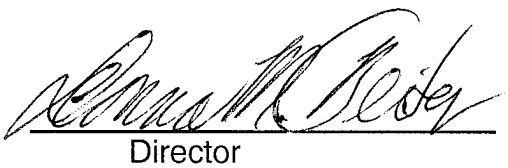
The Bylaws shall be reviewed every year, revised as necessary, and dated to indicate the time of the last review.

These Bylaws were adopted by majority vote of the Medical Staff at the Annual Meeting of January 22, 2010.

REVIEWED AND APPROVED:



Chief of Staff



Director

RULES OF THE MEDICAL STAFF

I. PATIENT AND STAFF RIGHTS AND RESPONSIBILITIES

A. Current GLA policies are considered a supplement to the Bylaws and Rules. The most current versions of policies will be in force, even if they are up-dated or amended before the next Annual Meeting of the Medical Staff and revision of the Bylaws and Rules. Examples are as follows:

(1) Compliance Committee (00-EI-02)
(2) Provider Responsibility for Workload and Billing Documentation (00-EI-03)
(3) Informed Consent (00-EI-04)
(4) Patient Grievance Process (00-EI-05)
(5) Patient Abuse (00-EI-06)
(6) Staff Nonparticipation in Patient Care (00-EI-07)
(7) Bioethics Committee (00-EI-08)
(8) Do Not Resuscitate Orders (00-EI-09)
(9) Withholding or Withdrawal of Life-Sustaining Treatment and Advance Directives (00-EI-10)
(10) Anatomical Gifts--Organ and Tissue Procurement (00-EI-11)
(11) Patient Rights, Responsibilities, and Denial of Rights (00-EI-12)
(12) Informed Consent for Research Subjects (00-EI-13)
(13) Data and Safety Monitoring Board (00-EI-14)
(14) On-Site Vendor Activities (00-EI-15)
(15) Prevention of Harassment (00-EI-16)
(16) Prevention of Sexual Harassment (00-EI-17)
(17) Potential Victims of Abuse (00-EI-18)
(18) Inter-Facility Transfer, Referral, and Patient Care Policy (00-EI-19)
(19) Verbal and Telephone Orders (00-EI-20)
(20) Restraints and Seclusion (00-10B-118-36)
(21) Management of the Impaired Provider (00-EI-22)
(22) Confidentiality of and Release of Information from Patient (Veteran) Records Under the Privacy Act (10A3-001NR-04)
(23) Radiation Safety (00-11-11QA-01)
(24) Peer Review Policy (0011-08)

B. All policies and pertinent regulations referred to in these Rules are available on the VAGLAHS Intranet and/or through the COS office

II. RESPONSIBILITIES OF THE MEDICAL STAFF FOR HEALTHCARE

A. Conduct of Care

(1) The VAGLAHS shall accept patients for healthcare only as authorized by DVA/VHA regulations in accordance with the Medical Staff Bylaws and

Rules. No distinction shall be made on the basis of race, creed, national origin, gender, advanced age, sexual orientation, or, in the case of handicapped persons, their disabilities.

(2) The management of the patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff.

(3) The same quality of patient care will be provided by all individuals with delineated clinical privileges, within and across departments and sites and among all staff members who have clinical privileges.

(4) Medical Staff members are responsible for complying with VAGLAHS policies and oversight bodies. They are also responsible for ensuring compliance with medical records policies regarding third party billings and collections. This includes the timely and accurate completion of the paper or electronic encounter forms used to document workload and to generate bills.

(5) All entries in the medical record will be completed and signed in a timely fashion. Entries into the record electronically (using the CPRS or DHCP progress note package or similar mechanism) should be signed when they are completed. Documents that are dictated and transcribed into the record should be signed as soon as they are uploaded into the system.

(6) Dual care is common throughout the VHA system. Although ideally each veteran should have a single primary care provider who oversees all aspects of care, some patients choose to see non-VA healthcare providers as well as VA providers. VHA Directive 2002-074 dated November 20, 2002 articulates VA policy on this issue. This directive may be summarized for use at GLA as follows:

a. Veterans seeking care, medications or supplies from VA must be enrolled in, and have at least one visit with a primary care provider;

b. If the veteran wishes to receive ongoing medication or services for primary care health needs, the veteran must be followed and managed by a VA primary care clinician and/or team, even if some of the care is provided in the community;

c. Specialty services may be provided for veterans receiving dual care following local and VISN guidelines. For GLA and VISN 22, these guidelines are under development.

d. In any event, for both primary and specialty care, the VA clinical record must document and support the need for all medications, testing and treatment recommended or provided by VA.

e. Any VA physician being asked to treat a veteran may, and in fact has, the ethical and professional responsibility to refuse to continue a specific

treatment prescribed by another provider (VA or community provider) if the physician believes the treatment is inappropriate.

f. The VA provider is entitled to hold the veteran patient responsible for:

(1) Informing the veteran's outside provider(s) of care being provided in the VA.
(2) Providing the VA provider with the name and address of all outside providers the patient is seeing.
(3) Obtaining all necessary records and documentation from an outside provider.

B. Consent:

Medical staff members are responsible for complying with VAGLAHS policies on informed consent, as detailed in VAGLAHS policy 00-00EI-47, and VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

(1) VAGLAHA does not recognize "general or blanket" consent and requires the patient's or appropriately designated surrogate's separate consent for each treatment, procedure, and therapeutic course of treatment.
(2) Signed consent will be documented using the electronic iMed Consent system in all cases not excepted by policy for procedures defined by policy.
(3) Verbal consent for low risk treatments and tests will be documented in the electronic medical record.
(4) In medical emergencies, the patient's consent is implied if immediate care is necessary to preserve life or serious impairment to health; the patient is unable to consent; consent from an appropriate surrogate is not feasibly available; and the patient's previously expressed wishes (for examples, an Advance Directive or know religious beliefs) are not opposed to the required treatment. In medical emergencies with these circumstances, the Chief of Staff or designated service chiefs will be notified and document that the emergency exception to obtaining signature consent was applied appropriately.

C. Emergency Services

(1) Emergency services available at the WLA Healthcare Center are designated Level II and the physician staffing is consistent with this designation. Emergency services are not available at other sites in the VAGLAHS. Emergency care at all other VAGLAHS sites will be provided either by calling 911 for mobile city or county emergency services. Members of the Medical Staff will provide care necessary to stabilize emergency patients while awaiting the arrival of paramedics. All applicants for emergency care are evaluated regarding the need for emergent care and treatment

is rendered as appropriate. Those requiring less than urgent care are triaged to appropriate treatment or referral venues.

(2) Emergency services are described in greater detail in respective VAGLAHS policies.

D. Admissions to the Hospital and Nursing Home Care Units

(1) Admission to one of the specialized healthcare facilities of the VAGLAHS, such as the Hospital or a Nursing Home, requires evaluation and authorization by a member of the Medical Staff with designated admitting privileges. Medical Staff members may not refuse an admission made or approved by another designated admitting practitioner.

(2) Except in an emergency, no patient shall be admitted to the VAGLAHS until a provisional diagnosis has been stated on the medical record and an attending physician identified.

(3) All admitted patients shall be attended by members of the professional staff who are assigned to a care line or clinical program concerned with the treatment of the disease for which hospitalization is required.

E. History & Physical Examinations

(1) Each inpatient admitted to the VAGLAHS shall have a complete history, physical examination and laboratory work as determined by the admitting practitioner.

(2) For patients admitted to an inpatient service of the medical center, the attending member of the medical staff must physically meet, examine, and evaluate the patient within 24 hours of admission (72 hours for the Nursing Home Care Unit or Domiciliary) including weekends and holidays. Documentation of the findings and treatment plan of the attending member of the medical staff must be in the form of an independent note or an addendum to the note by the resident or mid-level practitioner which must be entered by the end of the calendar day following admissions (or 3 calendar days in the Nursing Home Care Unit or Domiciliary).

(3) Dentists who are not oral and maxillofacial surgeons but who are responsible for hospitalized patients have the obligation to assure that the initial history and physical is performed by a physician, an oral and maxillofacial surgeon, or physician assistant or nurse practitioner under the supervision of a staff physician, and to obtain medical consultation and/or management when appropriate for patients with medical problems present upon admission or which arise during hospitalization. In the absence of concomitant medical problems, the physician's role, if required, may be limited to the admission history and physical examination. Dental history examinations will be written or dictated by Dentists.

F. Progress Notes

(1) Entries may be made in the progress notes by Medical Staff members, Registered Nurses, Licensed Vocational Nurses, Rehabilitation Medicine Therapists, Dietitians, Social Workers, Pharmacists, Clinical Trainees, and other qualified members of the health care team. Progress notes shall be titled, timed, dated and identified by the name and profession of the individual making the entry. All patient care notes shall be entered into the medical record as soon as possible but not later than the next day following the patient care being documented. If completion of the note requires transcription of a dictation, review of additional information not immediately available, or involves other extenuating circumstances, a brief, preliminary note containing necessary clinical data and recommendations shall be written into the record and the complete note shall be entered and signed as soon as possible. All emergency care notes will be entered as soon as possible after care is provided. Any entry by a clinical trainee shall include documentation of supervision as appropriate to the type of clinical care.

(2) Inpatient progress notes shall be written at sufficiently frequent intervals and in sufficient detail to document the clinical course of the patient, including significant changes in condition. Documentation will be consistent with VHA resident supervision guidelines and with VHA regulations and policies related to clinical and business compliance.

(3) Outpatient progress notes shall be written in a manner consistent with medical necessity and with sufficient detail to support the CPT and ICD-9 codes selected for the visit in question and consistent with VHA resident supervision guidelines.

G. Use of Therapeutics

Drugs used shall meet the standards of the United States Pharmacopeia, National Formulary, or AMA Drug Evaluations. Only drugs listed in the VA formulary may be used at the VAGLAHS. Policies determined by the Pharmacy and Therapeutics Review Committee provide exceptions to this rule.

H. Consultations

(1) Required Consultations: Except in an emergency, consultation with another qualified Medical Staff members is required when, in the judgment of the patient's Medical Staff member:

(a) The patient is not a good risk for operation or treatment;
(b) The diagnosis is obscure;
(c) There is doubt as to the best therapeutic measures to be utilized.

(2) Consultation Services: A consultant shall be a member of the medical staff well qualified to give an opinion in the field in which his/her opinion is sought. Qualifying as a consultant is determined by the Medical Staff on the basis of an individual's training, experience, and competence and is reflected in specific privileges to perform consultations within his/her field of expertise. Trainees or mid-level practitioners may participate in the performance of consultations under the supervision of a member of the medical staff with appropriate privileges.

(3) Essentials of a Consultation: A satisfactory consultation includes examination of the patient and the record. A recorded written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

(4) Responsibility for Requesting Consultation: The Medical Staff member responsible for the care of a patient is responsible for requesting and obtaining indicated consultations. Consultations may also be requested by mid-level practitioners, such as Physician Assistants, Nurse Practitioners, and other specially trained nurses, when they are acting within their approved Scope of Practice.

(5) Consultations shall be performed as soon as possible following a request to insure proper treatment of the patient and to prevent prolongation of hospital stay or excessive clinic waiting times. Emergency consultations can best be requested by phone and shall be completed in minutes to hours depending on urgency. Non-emergency consultation requests can go through routine channels. Routine consultations for inpatients shall be performed by the next day unless the requesting practitioner agrees that patient care and length of stay permits otherwise.

I. Discharge Planning

Adequate discharge planning is a requirement for proper completion of a patient's episode of care. Discharge planning shall be documented in the medical record and will provide for appropriate continuity of care.

J. Discharges

(1) Patients shall be discharged only on written order of the Medical Staff member responsible for the patient, with the exception that Residents may write discharge orders under the direct supervision of the Medical Staff.

(2) Patients desiring to sign out or leave Against Medical Advice (AMA) shall, whenever possible, be seen and counseled by a Medical Staff member. Any patient leaving AMA shall have a final note in the progress notes written by a Medical Staff member indicating the reason for leaving and any special disposition arrangements, such as drugs dispensed, etc.

K. Discharge Summaries

(1) A Hospital Summary should be written or dictated prior to or at the time of discharge. Hospital summaries prepared by Residents shall identify the attending Medical Staff member responsible for the patient and be co-signed by that person, except when authorized by the Director for self-approval of summaries.

(2) The Medical Staff member responsible for the summary is considered delinquent if the summary is not written or dictated within thirty days of discharge. If it becomes necessary to suspend privileges of the member, this shall be documented in the member's VA Personnel file. Suspension for delinquent records will be initiated by the Chief of Staff. The final summary shall be transcribed, reviewed and signed by the Medical Staff member within seven days from the date of dictation.

L. Problem Lists

The Medical Staff is responsible for the creation and maintenance of electronic problem lists on all patients receiving continuity care in the VAGLAHS. It is to be created on or before the third outpatient visit.

M. Autopsies

(1) Every member of the Professional Staff is expected to be actively interested in securing autopsies. It shall be the duty of all Medical Staff members to notify the Chief of Staff or his designee in certain cases to determine whether the case should be referred to the coroner, or if appropriate to secure autopsy. These cases include:

(a) Any sudden unexplained death due to injury or suicide
(b) Deaths that are known or suspected to have resulted from unnatural causes (e.g. accidental, suicidal, homicidal), including drug reactions and therapeutic misadventures
(c) Deaths of patients who are participants in approved clinical trials or research protocols

(2) It is particularly important for the Medical Staff to encourage post-mortem examination in the following circumstances:

(a) Death in which the cause is unknown or not fully established on clinical grounds, or which an autopsy could further elucidate medical complications.
(b) Death that occurs during the intraoperative or immediate post-operative period of any surgical or invasive diagnostic/therapeutic procedure.
(c) Death on arrival or within 24 hours of admission to (VAGLAHS), sudden or unexpected death.

(d) Death in which autopsy could disclose an illness that may have a bearing on the health and welfare of survivors, including organ transplant recipients.

(e) Deaths that are known or suspected to have resulted from communicable diseases, occupational, or environmental hazards.

(3) No autopsy shall be performed without proper consent. All autopsies shall be performed by the VAGLAHS pathologist or by a physician delegated this responsibility. The Department of Pathology and Laboratory Medicine is responsible for notifying the Attending physician of the deceased patient about the exact time and place for the proposed autopsy. Preliminary or provisional anatomical diagnoses shall be reported within 72 hours. The final protocol shall be completed and signed by the pathologist within 60 days.

(4) Quarterly summaries of the rate of autopsy requests and autopsies performed shall be submitted to the MEC.

N. Research

(1) All research on human subjects must be approved by the Research and Development Committee or appropriate subcommittee of the Research and Development committee (eg. Institutional Review Board) as required by VHA handbook 1200.01 and 1200.05. Research proposals and complete research protocols must be submitted in writing to the Research and Development Committee for consideration and approval prior to use.

(2) Human Subjects Research will not be conducted without the express written consent of the patient or legal guardian/conservator.

(3) Research will not be performed on children at VAGLAHS unless a waiver approving such research has been obtained from the Chief Research and Development Officer at VACO.

(4) The principal investigator is responsible for assuring adequate medical record documentation of the involvement of patients in research. When a research study is initiated, the consent form should be placed in the medical record, the medical record should be "flagged" to indicate the patient is a research subject if required by the Institutional Review Board, and an On Study Research Note written. Research progress notes should be written or dictated for inclusion in CPRS at appropriate intervals during the study. At the conclusion of the study, a Research Termination Note should be written and the research "flag" should be removed from the medical record.

III. MEDICAL RECORDS

A. Basic Administrative Requirements

(1) The Medical Staff shall be held responsible for the preparation of a complete medical record for each patient. The record shall include identifying data, chief complaints, history, physical examination, special reports (such as consultations, clinical laboratory, x-ray and others), provisional diagnosis, medical and or surgical treatment, operative reports, pathological findings, progress notes, including condition on discharge (discharge note) and final diagnoses, complete American Joint Commission on Cancer (AJCC) staging as applicable, an electronic problem list, and final summary.

(2) The use of symbols and abbreviations is discouraged. Final diagnoses shall be recorded in full, and without the use of either symbols or abbreviations. In addition, a list of Do Not Use Abbreviations will be reviewed and approved by the MEC at least annually and will be prohibited from use in the Medical Record.

(3) The use of "cut and paste" or copying sections from other portions of the medical record into new entries is discouraged. When sections are copied from other entries, this must be indicated by the use of quotation marks and the date and author of the original entry must be indicated, even if it is the same person making the current entry. Excessive copying or copying that is not indicated as such may be considered evidence of below standard quality and documentation of care.

(4) Free access to medical records shall be afforded to Medical Staff members for Research and Development Committee or appropriate Research and Development Committee subcommittee approved study and research, consistent with preserving the confidentiality of the patient's personal information.

(5) All operations will be noted and at least briefly summarized in the medical record immediately after surgery. A full and complete description of the procedure must be written or dictated for the medical record the same day and as soon as possible after the procedure.

(6) All tissues removed at operation, except for limited categories (as determined by the Invasive and Other Risk-Associated Procedures Improvement Committee (IPIC) shall be sent to Pathology for such examination as may be necessary to arrive at a histologic diagnosis. The pathologist's signed report shall be part of the medical record.

(7) All records are the property of the VAGLAHS, and shall not be removed from the premises without court order, subpoena, or statute except when necessary for continuity of care and treatment. In case of readmission of a patient, all previous records on file shall be available for the use of the staff.

B. Privacy and Confidentiality Issues

(1) The medical record is a confidential document and patients have a right to confidentiality under the Health Insurance Portability and Accountability Act (HIPAA).

(2) VAGLAHS policies and procedures related to this issue are described in detail in SOP 10A3-00INR-04.

IV PHYSICIAN'S ORDERS

A. General Requirements

(1) All orders for treatment shall be documented in the medical record. Handwritten orders must be legible and be signed with the author's name and either the printed name or the personal identification number (PIN) to follow the signature. Electronic orders will be signed electronically.

(2) Verbal and telephone medical orders from an authorized prescriber may be accepted by those so authorized when this approach will best facilitate medical care, as detailed in Corporate Policy 00-EI-20 Verbal and Telephone Orders).

(3) Non-physician clinical professionals may write orders as identified in their clinical privileges or approved scope of practice.

B. Medication Orders

(1) Drugs shall be prescribed only by members of the Medical Staff, residents, and practitioners working within a Scope of Practice who are under the direct supervision of a member of the Medical Staff The prescription of a drug shall be based on an appropriate encounter with the patient that includes medical decision-making based on an assessment of the patient's history and physical or laboratory findings. The encounter shall be documented in the medical record.

(2) If an order for any medication for a hospitalized patient expires during the night, it shall be called to the attention of the Medical Staff member the following morning or earlier should the patient's condition require additional medications.

C. Automatic Stop Orders

Controlled substances, sedatives, antibiotics and anticoagulant drugs that are ordered without time limitation of dosage shall be automatically discontinued after a specified period of time as determined by the Pharmacy and Therapeutics Review Committee. The Medical Staff member will be notified by the responsible Registered Nurse of the cancellation of the drug order.

D. Investigational Drugs

Investigational drugs will be used according to DVA/VHA and relevant FDA regulations.

E. Formulary System

Only drugs listed in the formulary may be used in the VAGLAHS. Policy determinations by the Pharmacy and Therapeutics Committee provide exceptions to this rule.

V. RESIDENTS

A. The Residents shall consist of those individuals at the VAGLAHS, with or without compensation, who are graduates of bona fide medical, dental, podiatric medical, optometry or psychology programs of postgraduate training and education. They are recommended for appointment by the Deans Committee for a limited period of training subject to the regulations of DVA/VHA. They are not included for purposes of clinical privileges (except as noted in Section C below) and will function only under the supervision of, and within the clinical privileges as deemed appropriate by and granted to, a qualified practitioner who has clinical privileges in the area being supervised. Trainees will have graduated levels of patient-care responsibility based on their knowledge, level of training and demonstrated competence. They are expected to function in a manner that is consistent with the Medical Staff Bylaws and Rules; they may serve as voting members on designated VAGLAHS committees.

B. The office of the Associate Chief of Staff/ Education must approve in advance all residents, medical students, and visiting trainees who will have clinical training at VAGLAHS.

C. GLA adheres to the guiding principles enumerated in the VHA Resident Supervision Handbook 1400.1. The Medical Staff specifically endorses the following guiding principles:

(1) The attending physician must meet each new inpatient within 24 hours of admission (including weekends and holidays) to an acute unit and personally document that encounter in the patient's medical record no later than the end of the calendar day following admission, either by writing an attending note or by writing an addendum to the resident's admission note.

(2) The medical center must clearly designate an attending physician for night float admissions.

(3) Supervising practitioners are expected to be personally involved in the ongoing care of the inpatients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the

resident.

(4) The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an inpatient service of the medical center is appropriate and based on the specific circumstances of the patient's diagnoses and therapeutic regimen; this may include physical activity, medications, diet, functional status, and follow-up plans. Evidence of this assurance must be documented by the supervising practitioner's countersignature of the discharge summary or discharge note.

(5) The supervising practitioner, in consultation with the resident, ensures that the transfer of the patient from one inpatient service to another or transfer to a different level of care is appropriate and based on the specific circumstances of the patient's diagnoses and condition. The supervising practitioner from the transferring service must be involved in the decision to transfer the patient. The supervising practitioner from the receiving service must treat the patient as a new admission and must write an independent note or an addendum to the resident's transfer acceptance note. NOTE: This provision covers transfers into and out of intensive care units or transfers to extended care. The only exception is whenever the same supervising practitioner is responsible for the patient across different levels of care.

(6) A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents and their involvement must be documented in the medical record.

(7) For patients admitted to, or transferred into, an ICU of the medical center, the supervising practitioner must physically meet, examine, and evaluate the patient as soon as possible, but no later than 24 hours after admission or transfer, including weekends and holidays. An admission note or addendum to the resident's admission note is required within 1 day of admission. Because of the unstable nature of patients in ICUs, frequent evidence of involvement of the supervising practitioner is expected. Supervising practitioner involvement is expected on a daily or more frequent basis and must be documented in the medical record.

(8) Attending staff must be physically present in the clinics.

(9) New patients to the facility require a higher level of supervising practitioner documentation than other outpatients. Each new patient needs to be seen by or discussed with the supervising practitioner. This involvement must be documented in the medical record.

(10) A supervising practitioner is responsible for clinical consultations from each outpatient clinic to another supervising practitioner within the facility. When residents are involved in consultation services, the supervising

practitioner is responsible for supervision of these residents.

(11) The supervising practitioner responsible for continuing care in the outpatient setting must be identifiable for each resident's patient care encounter. Return patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate.

(12) The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from an outpatient clinic is appropriate.

(13) Each new patient admitted to the nursing home must be seen by the responsible supervising practitioner within 72 hours of admission. The attending must write an independent note or an addendum to the residents note to document this interaction.

(14) The supervising practitioner must be identifiable for each resident's nursing home patient care encounter. Extended care patients must be seen by, or discussed with, the supervising practitioner at such a frequency as to ensure that the course of treatment is effective and appropriate.

(15) Attending staff must be physically present in the emergency department to supervise residents providing care to patients. Attendings must personally see these patients or discuss their care including discharge with the residents providing same and the attending's level of involvement must be documented in the medical record.

(16) A supervising practitioner is responsible for clinical consultations from each specialty service provided patients in the emergency department. When residents are involved in consultation services, the consulting service supervising practitioner is responsible for supervision of these residents. Residents from a consulting service are expected to contact their supervising practitioners while the patient is still in the emergency department in order to discuss the case and to develop and recommend a plan of management. The emergency room practitioner is responsible for the disposition of the patient.

(17) The attending physician must write a pre-procedural note or an addendum to the resident's pre-procedural note within 30 days of the date of all electively scheduled procedures in the operating room or procedural units if a resident is involved in caring for the patient. This note must describe the pertinent findings of the history and physical examination, diagnosis, plan for treatment, and/or choice of specific procedure to be done.

(18) All surgical and diagnostic procedures performed in the operating room or procedural suites will be supervised by an attending physician who is physically present in the procedural area. The level of staff involvement in O.R. procedures as

defined in the VistA Surgical Package must be documented in the computerized surgical log.

(19) An attending physician must write or cosign the patient's discharge summary or discharge note.

(20) A listing of residents deemed competent to perform an enumerated set of clinical procedures (on the units or in clinics) will be available to the medical and nursing staff on the GLA intranet.

(21) Chief residents and fellows acting without supervision, or residents allowed to function outside of the training activity (e.g. hired to cover Admitting area), must apply for and be granted clinical privileges through the usual credentialing process.

(22) It is expected that all trainees supervised by the Medical Staff will have been approved by the ACOS/Education.

D. **Medical Students**

The attending physician is ultimately responsible for the evaluation and management of the patient and for the supervision of all trainees assigned to work with him/her. While some of the day-to-day supervision of medical students may be delegated to residents, the attending retains medical-legal responsibility for the patient's care.

(1) Medical student notes must be co-signed by an attending member of the medical staff or by a licensed resident. Medical student notes will be identified as such and will not be viewable prior to co-signature.

(2) All co-signers of medical student notes must write an addendum indicating their independent evaluation and conclusions regarding the patient.

(3) When a resident is the co-signer, the resident must also identify the attending with whom the case was discussed, as appropriate to any note by the resident.

VI. QUALITY IMPROVEMENT & RISK MANAGEMENT

A. The Medical Staff shall participate in all quality and appropriateness of patient care reviews undertaken by Quality Management.

B. The Medical Staff shall participate in the utilization management plan of the VAGLAHS.

C. The Medical Staff shall participate in the ongoing quality improvement activities of the VAGLAHS.

VII. IMPAIRED PROFESSIONAL PROGRAM

This program is described in a separate VAGLAHS policy statement (GLA Policy 00-EI-22 on the Management of the Impaired Provider) and in VA Directive 5383, VA Drug Free Work Place.

VIII. EMERGENCY PREPAREDNESS

All Medical Staff members will be responsible for reporting to their regular duty assignments as soon as possible in the event of a disaster within the VAGLAHS and upon notification when mass casualties occur within the community. The Chief of Staff, the Director and other executive management officials will work as a team to coordinate activities and give directions. If it becomes necessary to evacuate patients during or because of the disaster, the Chief of Staff will authorize the movement of patients as directed by the Director or his/her designee. All policies and decisions concerning patient care will be the joint responsibility of the Chief of Staff and the Director. The VAGLAHS Disaster Plan shall be rehearsed at least twice a year. These exercises shall be realistic and involve key hospital personnel. An evaluation or critique shall be conducted after each disaster exercise and a written report prepared citing recommendations for improvement for follow-up attention.

IX. DISCIPLINARY ACTION

Failure to comply with these Bylaws and Rules may result in disciplinary action.

X. AMENDMENTS

These Rules may be amended at any time by majority vote of the Medical Executive Committee or by majority vote at the Annual Meeting or any Special Meeting of the Medical Staff. Approved Amendments become effective when approved by the Director.

XI. REVIEW

The Rules shall be reviewed every year, revised as necessary, and dated to indicate the time of the last review.

These Rules were adopted by majority vote of the Medical Staff at the Annual Meeting of January 22, 2010.

REVIEWED AND APPROVED:

Chief of Staff

Director