Department of Veterans Affairs

## Nebraska-Western Iowa Health Care System

# MEDICAL STAFF

# RULES and REGULATIONS

**February 2007**

**MEDICAL STAFF RULES AND REGULATIONS**

# TABLE OF CONTENTS

**If you are reading this document online, you may point and click on the desired topic below for easy online access to that area of these Rules and Regulations.**

**Department of Veterans Affairs**
**Nebraska-Western Iowa Health Care System**

# RULES AND REGULATIONS OF THE MEDICAL STAFF

## A. GENERAL

These Rules and Regulations of the Medical Staff of the Nebraska-Western Iowa Health Care System are to supplement and/or implement the Bylaws. The Rules and Regulations are subject to approval by the Director, the Medical Staff, or the Executive Committee of the Medical Staff (XCOM) as may be necessary to implement the general principles found in the Bylaws of the Medical Staff, Department of Veterans Affairs Nebraska-Western Iowa Health Care System. They shall be considered part of the Bylaws, except that they may be amended or repealed at any regular meeting of the Medical Staff or the Executive Committee of the Medical Staff at which a quorum is present and without prior notice, or at any special meeting on notice, by a majority of those present and eligible to vote. Such changes shall become effective when approved by the Director.

These rules and regulations apply only to care provided in VA-owned facilities. VA physicians attending VA-eligible inpatients in contract hospitals shall be subject to the medical staff rules and regulations of the facility in which privileges are held.

Unless otherwise designated, “inpatient” includes acute, extended and residential care.

## B. ADMISSION AND DISCHARGE OF PATIENTS

1. The Nebraska-Western Iowa Health Care System shall accept patients for care and treatment according to VA regulations concerning eligibility for care.

2. A patient may be admitted to the inpatient services of the Health Care System only by a member of the Medical Staff with admitting privileges, or a house officer acting for such Staff. All practitioners shall be governed by the official admitting policy of the Health Care System.

3. A physician member of the Medical Staff shall be continuously responsible for the medical care and treatment of each inpatient and each outpatient of the Health Care System, for the performance of a complete history and physical examination on each patient, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these continuing responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

4. Except in an emergency, no patient shall be admitted to inpatient status at the Health Care System until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

5. Areas of preferred bed utilization and assignment of patients in acute care shall be as follows: Medical/Surgical encompassing surgical specialties, general internal medicine, neurology, dermatology and intensive care; and Mental Health & Behavioral Sciences, including general psychiatry, psychiatric intensive care and substance abuse. Patients may be admitted without regard to the above restrictions if the wards of primary assignment are filled. It is understood that when deviations are made from assigned areas as indicated above, action may be taken to correct these assignments in keeping with transfer priorities.

6. Patient Transfers

Transfer priorities shall be as follows:

- Receiving area to appropriate patient bed.
- From extended care to acute care.
- From Intensive Care Unit (ICU) to general care area.
- From temporary placement in an inappropriate geographic or clinical department area to the appropriate area for that patient.
- From acute care to extended care.

7. The physician(s) in charge of the patient's management shall be responsible for the protection of the patient from self-harm and to assure the protection of others whenever the patient(s) might be a source of danger from any cause whatever.

8. For the protection of patients, the medical and nursing staffs, and the Health Care System, certain principles are to be met in the care of the potentially assaultive or suicidal patient:

a. Any patient known or suspected to be assaultive or suicidal in intent shall be admitted to the psychiatry unit. If there are no accommodations available in this area, the patient shall be referred, if possible, to another appropriate institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the Health Care System and, as a temporary measure, bars or locks may be placed on the windows of the patient's room and special nursing provided. Such patients should spend the daytime hours in the area where special observation and therapy are available.

b. Any patient known or suspected to be assaultive or suicidal must have immediate and prompt consultation by a member of the Mental Health & Behavioral Science Department staff. Such consultation request shall be answered promptly.

c. If locked restraint and/or seclusion is initiated, there must be complete documentation in the clinical record. A detailed description of the process, procedure, documentation and other requirements for use of restraint and/or seclusion shall be contained in official, published Health Care System policy and amended from time to time as appropriate. The policy is herein incorporated into this paragraph 8c by reference.

9. Admission/Discharge Involving Intensive Care Units

If any question as to the validity of admission to or discharge from the intensive care unit should arise, that decision is to be made through consultation with the unit director or chief of department.

10. The attending practitioner is required to document the need for continued acute hospitalization after specific periods of stay as identified by Utilization Management. Upon request, the attending practitioner must provide justification of the necessity of or cause for continued hospitalization that exceeds criteria. The patient must be discharged promptly when continued stay is determined to be inappropriate by mechanisms which are currently in place. Failure of compliance shall be brought to the attention of the Department Chief for use in reappraisal and the Executive Committee of the Medical Staff (XCOM) for action.

11. Patients shall be discharged only on a written order of the attending practitioner, designee or supervised house officer assigned to the patient and acting for the Staff. Should a patient leave the Health Care System against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

12. In the event of a Health Care System death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. Policies with respect to release of dead bodies shall conform to local law and VA regulations.

13. It shall be the duty of all Staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only upon witnessed consent, either by signature or electronic verbal recording, and obtained in accordance with state law and VA regulations. All autopsies shall be performed by the Health Care System pathologist, or by a practitioner delegated this responsibility. The results shall be conveyed to the attending physician and Department Chief and be employed in the Health Care System Performance Improvement function.

C. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the timely preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, or of clinical laboratory and radiology services, and others; provisional diagnosis; problem list; initial assessment and plan; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed.

2. A complete admission history and physical examination must be performed by a licensed independent practitioner who has been granted privileges to do so. In addition, the history and physical may be performed by an Advanced Practice Nurse Practitioner (APRN) or a Physician Assistant (PA), provided he/she has been appropriately trained and has been authorized to do so within his/her Scope of Practice at this Health Care System, while under the supervision of, or through appropriate delegation by, his/her supervising physician. All history and physicial examinations performed by an Advanced Practice Nurse Practitioner or a Physician Assistant shall be countersigned by the supervising or attending physician within 24 hours.

3. A complete admission history and physical examination shall be recorded within 24 hours of admission to acute care, and within 72 hours of admission to extended care, and authenticated by Staff accorded this privilege. This report should encompass all pertinent findings resulting from an assessment of all the systems of the body, including cognitive skills and social status/needs. A previous history and physical can be utilized if it was completed within 30 days prior to the day of admission or outpatient treatment, provided the history and physical is updated within 24 hours to reflect the patient's status at the time of admission or service. If such a history and physical is utilized, the attending practitioner shall review the findings, assess the patient, and make an entry into the progress notes regarding any changes in patient status since completion of the history and physical.

4. If a patient is having surgery or other procedure that places the patient at risk and/or involves the use of sedation or anesthesia, there must be an update to the patient's condition PRIOR to the start of surgery or procedure, or the surgery or procedure shall be canceled. In such cases, the update and the preanesthesia assessment may be accomplished in a combined activity, and/or the update may be documented in the progress notes.

5. When the history and physical examination, and any indicated laboratory and radiographic examinations are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless an exception is granted by the chief of the clinical department concerned in response to a grave emergency such as need for a lifesaving tracheotomy.

6. Pertinent progress notes shall be recorded in the hospital record sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on all acute care patients

and, if needed, more frequently on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem. Progress notes shall be written at last every 30 days for extended care. Staff entries shall be made to document participation and oversight of care for patients to whom house officers, physician assistants and nurse practitioners are assigned. A Staff entry shall be made before surgery or major invasive procedure and whenever the patient's condition changes significantly. Nurses, house officers, dietitians, pharmacists, social workers may make record entries, relevant to participation in the patient's care, and other associated and allied health personnel.

7. Invasive procedure (operative) reports shall include a detailed account of the findings as well as the details of the technique employed. The reports shall be written (or dictated) immediately following the procedure for outpatients as well as inpatients and the report promptly signed by the operator and made a part of the patient's current medical record. A progress note shall also be entered in the patient's record immediately post-operatively, summarizing the findings and the procedure performed. Overprinted forms and anatomical illustrations may be employed.

8. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

9. All clinical entries in the patient's medical record shall be accurately dated and authenticated by the appropriate individual. The Staff shall authenticate the house officer's history, physical, discharge summary, pathology and radiology reports, reports of operation/invasive procedure as well as reports of EKGs, EEGs, nuclear scans and consultations and other entries which may be specified from time to time by the XCOM. Authentication means to establish authorship by written signature, identifiable initials or computer key. The use of a rubber stamp or electronic signature is acceptable under the following conditions:

    a. The practitioner whose signature the rubber stamp or electronic entry represents is the only one who has possession of the stamp or computer code and is the only one who uses it; and

    b. The practitioner places in the administrative offices of the Health Care System a signed statement to the effect that he/she is the only one who has the stamp or that he/she accepts responsibility for security of any administratively assigned computer code. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations shall be kept on file in the record room.

10. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. This shall be deemed equally as important as the actual discharge order.

11. A discharge clinical resume (summary) shall be written or dictated on all medical records of patients hospitalized. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. The Staff practitioner responsible for the care of the patient shall authenticate all summaries.

12. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

13. Medical records may be removed from the Health Care System's jurisdiction and safekeeping only by court order, subpoena, or statute in accordance with VA regulations. All records are the property of the Health Care System and shall not otherwise be taken away without permission of the Director. In case of readmission of a patient, all previous records shall be available for

the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of medical records from the Health Care System is grounds for suspension of the clinical privileges of the practitioner for a period to be determined by the Executive Committee of the Medical Staff. VA disciplinary action may also be invoked.

14. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. The chief of department shall approve projects before records can be studied. Subject to the discretion of the Director, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Health Care System.

15. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by appropriate VA authority.

16. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

17. Medical record content shall conform to Department of Veterans Affairs regulations, the Rules and Regulations of the Medical Staff and congruous policies adopted by the Executive Committee of the Medical Staff. The medical record, including discharge summary, shall be complete at the time of discharge with the exception of irregular discharge or death. These latter shall be complete within 24 hours of discharge or completion of an autopsy. Deficiencies in medical record content shall be identified within seven (7) calendar days of discharge. The record shall be totally complete no later than 30 days after discharge or it will be delinquent. Practitioners delinquent in completion of medical records shall be reported to the chief of department involved and shall be subject to corrective action. Such corrective action to be taken shall be defined by the Executive Committee of the Medical Staff and implemented by the Chief of Staff or chief of department.

D. GENERAL CONDUCT OF CARE

1. Specific consent that informs the patient of the nature of and risks inherent to any special treatment, invasive procedure or research study must be obtained unless specifically excluded by action of the Medical Staff. Standard VA or locally developed/modified forms shall be used for this purpose.

2. Medical Staff, including podiatrists and dentists, may write orders. All orders for treatment shall be in writing. Verbal orders issued by authorized practitioners may be accepted and entered in the medical record as outlined in Health Care Systems Memoranda COS-010 and COS-020. The attending physician(s) and the chief of department may write patient care orders for all patients on their service. The house staff may also write patient care orders on all patients on their service; however, this privilege for house officers does in no way preclude writing of orders by the attending physician or Department Chief. Orders may be written by other professionals according to policy established by the Executive Committee of the Medical Staff.

3. Orders must be written clearly, legibly, and completely. Orders, which are illegible or improperly written, shall not be carried out until rewritten or understood by the nurse or unit clerk.

4. All previous orders, <u>except DNR</u>, are canceled when patients go to surgery. DNR orders shall be addressed as outlined in policy number COS-048.

5. House officers appointed to the facility may participate in the provision of patient care and services. They shall be responsible to an appropriate member of the Medical Staff who shall closely supervise their activities on a daily basis. Failure to participate in the teaching program shall not constitute cause for the revocation of privileges.

6. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigation may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Federal Drug Enforcement Administration and the Department of Veterans Affairs.

7. Any qualified practitioner with clinical privileges in this Health Care System can be called for consultation within his/her area of expertise. Department Chiefs shall assign consultation requests to appropriate Staff members.

8. The attending practitioner is primarily responsible for requesting consultation when indicated.

E. GENERAL RULES REGARDING SURGICAL CARE

1. The Chief of the Surgery Department shall implement written policies governing the use of the operating rooms. He/she is the final authority in the conduct of the surgical department.

2. Except in emergencies with imminent threat to life or limb, the preoperative history, physical, diagnosis and appropriate laboratory tests must be recorded on the patient's medical record by a staff member responsible for the patient's care prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

3. A patient admitted for dental care is a dual responsibility of the dentist and physician member of the Medical Staff. It is recognized that some Staff Members hold degrees in both medicine and dentistry, and thus can perform all functions listed below.

   a. Dentists' responsibilities:

      (1) A detailed dental history justifying hospital admission;

      (2) A detailed description of the examination of the oral cavity and a preoperative diagnosis;

      (3) A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the Health Care System pathologist for examination;

      (4) Progress notes as are pertinent to the oral condition;

      (5) Clinical resume (or summary statement).

   b. Physicians' responsibilities:

      (1) Medical history pertinent to the patient's general health;

      (2) A physical examination to determine the patient's condition prior to anesthesia and surgery;

      (3) Supervision of the patient's general health status while hospitalized.

   c. The discharge of the patient shall be on written order of the dentist member of the Medical Staff.

4. A patient admitted for podiatric care shall follow the same procedures as for dental care.

5. Consent forms shall be those authorized by the Department of Veterans Affairs and their executor shall follow established VA procedures.

6. The use of any anesthetic agent, other than for local infiltration or topical application, shall be under the control and supervision of the Chief of the Anesthesiology Section of the Surgery Department. The Chief of the Anesthesiology Section is responsible for the quality and appropriateness of anesthesia care delivered throughout the Health Care System. The same level of care shall be provided to all patients who receive analgesic or sedative agents that may impair vital functions.

7. The anesthesiologist or anesthetist shall maintain a complete anesthesia record, to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition in all instances when spinal, general or major regional anesthesia is involved. A licensed independent practitioner shall assess the patient's condition prior to administering any agent that impairs protective reflexes.

8. All tissues removed at the operation shall be sent to the Health Care System pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

F. EMERGENCY SERVICES

1. The Medical Staff shall adopt a method of providing medical coverage in the Emergency Room at the Omaha Division. This shall be in accord with the Health Care System's basic plan for the delivery of such services. In the event of a medical emergency situation at a Division where acute care is not provided, the local emergency number (911 or otherwise designated) shall be called. The physician shall direct care of the patient until emergency personnel arrive at the Division. Upon arrival of emergency personnel, the patient shall be immediately transferred to the closest facility that can provide emergency care.

2. An appropriate medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's hospital record, if such exists. The record shall be a prescribed VA form and shall include:

   a. Adequate patient identification;

   b. Information concerning the time of the patient's arrival;

   c. Pertinent history of the injury or illness, including relevant details about the first aid or emergency care given the patient prior to his/her arrival at the Health Care System;

   d. Description of significant clinical, laboratory and radiological findings;

   e. Diagnosis;

   f. Treatment given;

   g. Condition of the patient on discharge or transfer; and

   h. Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

3. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

4. In the event of the need for the care of mass casualties at the time of any major disaster, the facility's Emergency Management Plan shall be followed. This Plan is based upon the Health Care System's capabilities in conjunction with other emergency facilities in the community, and has been developed by the Safety Manager in coordination with at least one member of the Medical Staff, the Nurse Executive or his/her designee, and a representative from Health Care System administration.

5. Members of the Medical Staff shall follow the Emergency Management Plan in the event of an internal or external disaster (for Disaster Privileges, see Section J.7.).

6. All physicians shall be assigned to posts (either in the Health Care System or in the auxiliary hospital, or in mobile casualty stations) and it is their responsibility to report to their assigned stations. The chiefs of the clinical departments in the Health Care System and the Director of the Health Care System shall work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Health Care System to another, or evacuation from Health Care System premises, the chiefs of the clinical departments during the disaster shall authorize the movement of patients. All policies concerning direct patient care shall be a joint responsibility of the Department Chiefs, Nurse Executive and the Director of the Health Care System. In their absence, the assistant chief, or designee, and an alternate in administration shall be next in line of authority respectively.

G. AMBULATORY CARE SERVICES

1. The Medical Staff shall provide ambulatory care services at a level comparable to those provided to inpatients.

2. A complete history and physical examination shall be recorded on every patient at the time of admission to the program. Any history and physical completed prior to admission, regardless of when completed, must be updated at the time of admission.

3. An appropriate medical record shall be kept on every ambulatory care patient. It may be consolidated with the patient's inpatient record if one exists, or may stand alone if so authorized by the Executive Committee of the Medical Staff. The record shall include:

   a. Adequate patient identification.

   b. Entries sufficient to describe the patient's condition(s) and their progress and response to treatment. Staff entries shall be sufficient to document the level of care provided.

   c. An adequate listing of medications prescribed for the patient, including dose, frequency, and amount ordered.

   d. Laboratory and radiographic reports.

   e. Reports of consultations and special studies.

   f. Operative reports of all ambulatory care procedures.

   g. A listing of current problems/diagnoses, operative procedures and medications in summary or problem list form.

   h. Discharge notes, including instructions given to the family and/or significant other if continuing care is required.

   i. Authentication requirements are the same as specified in Section C7 of these Rules and Regulations.

## H. MEDICAL STAFF MEETINGS

The annual meeting of the Medical Staff shall take place during the month of October. Notice regarding time and place shall be mailed to each member of the Staff at least one week in advance.

## I. PROCEDURE FOR APPOINTMENT EVALUATION

### 1. APPLICATION FOR APPOINTMENT

a. All applications for appointment to the Medical Staff shall be completed utilizing the electronic Web-based VetPro system. The application shall require detailed information concerning the applicant's professional qualifications, including education, training, experience, current competence, health status, professional liability insurance, and certification, if applicable; shall include the name of peers and institutions who have had extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's current professional competence and ethical character. The applicant shall provide full information regarding licensure and registration, including DEA, and any professional sanctions, including pending or actual reduction in medical staff status, clinical privileges, licensure, and registration, whether voluntary or involuntary in nature, as well as all malpractice litigation.

b. For identification, the applicant shall provide a clear copy of his/her current driver's license (including picture) or other valid photo identification. This copy of the identification with photo may be distributed to peers and institutions who have experience in observing the applicant to verify appropriate confirmation of identification.

c. At personnel processing by the Human Resources Department and at arrival to the appropriate credentialing service, comparison between the application photo and the applicant presenting for service can be completed.

d. A detailed description of the requirements, process, and procedure for application for appointment to the Medical Staff, verification of credentials, forms prescribed, and mechanisms for approval shall be maintained in a Credentialing and Privileging Manual approved by the XCOM and the Director.

e. Inquiries regarding the applicant shall be made to the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB), to the Health and Human Services Office of the Inspector General (HHS OIG) website, and to the Federation of State Medical Boards (FSMB) at the time of application for appointment.

f. The applicant shall execute a statement that he/she has received and read a copy of the Bylaws, Rules and Regulations of the Medical Staff as well as relevant Health Care System and Department of Veterans Affairs policies, and that he/she agrees to be bound by the terms thereof.

g. Each practitioner shall sign an ethical pledge at a time no later than initial appointment to the Medical Staff as described below:

*If appointed to the Staff of this Health Care System, I understand and accept the obligation to provide continuous care to all patients for whom I am responsible in the Health Care System; in my absence, I will delegate care of my patients to a willing and qualified practitioner. I understand and accept the requirements for house officer supervision, including the need to make daily rounds on all inpatients for whom I am designated as the attending physician/surgeon and to make sufficient entries in the clinical record to clearly document my participation. When I am the assigned supervisor for electroconvulsive therapy or for an invasive procedure which involves the use of the operating rooms, radiology equipment, endoscopes, cardiac catheters, or significant risk to the patient, I will: (1) evaluate the patient prior to the procedure; (2) be present*

*during its performance; and (3) document my findings and involvement in the medical record. I signify I have received, read, and agree to be bound by the current Bylaws, Rules and Regulations of the Medical Staff and the Health Care System policies consistent with them, and other such policies, rules and regulations which may be issued from time to time, and acknowledge the provisions in the Bylaws, Rules and Regulations for release and immunity from civil liability. I agree to accept committee assignments and other reasonable duties assigned to me by competent Medical Staff or Health Care System authority. I promise to maintain the highest personal and professional ethics while a Staff member. I agree to report all final judgments or settlements in professional liability actions involving me.*

h. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, physical and mental health, character, ethics and other qualifications, and for resolving any doubts about such qualifications.

i. The completed VetPro application shall be submitted to the office of the chief of the clinical department in which appointment will be made. In collaboration with the Human Resource Management Service, letters of reference shall be collected and primary source verification shall be obtained, to the extent possible, for all items specified. The application and all supporting materials and the recommendation of the Department Chief shall then be transmitted to the Professional Standards Board. A separate application requesting clinical privileges must be submitted concurrently to the chief of the appropriate clinical department. After review, it will be forwarded with the Department Chief's recommendations to the Professional Standards Board.

j. By applying for appointment to the Medical Staff and/or requesting clinical privileges, each applicant thereby: (1) signifies his/her willingness to appear for interviews in regard to his/her application; (2) authorizes the Health Care System to consult with members of medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her current competence, health status, character and ethical qualifications; (3) consents to the Health Care System's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as of his/her moral and ethical qualifications for Staff membership; (4) releases from any liability all representatives of the Health Care System and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials; and (5) releases from any liability all individuals and organizations who provide information to the Health Care System in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for Staff appointment and clinical privileges, including otherwise privileged or confidential information.

2. APPOINTMENT PROCESS

The application for appointment shall be considered concurrently with the application for initial clinical privileges. Appointment shall be made to the clinical department(s) most appropriate to the applicant's credentials. No appointment shall be effected without the simultaneous extension of clinical privileges.

3. EVALUATION PROCESS

a. Proficiency reports shall be completed annually by the Department Chief of primary appointment on each practitioner employed on a full- or part-time basis and in the format prescribed by Department of Veterans Affairs regulations. Particular consideration shall be given to such items as clinical performance, including the quality and appropriateness of care provided, participation in continuing education, attendance

at staff, department or committee meetings, timely completion of records and compliance with Health Care System policy and Medical Staff Bylaws, Rules and Regulations.

b. If, at any time, the performance of a member of the Medical Staff is deemed to be less than that necessary to fully meet the requirements of the Department of Veterans Affairs, the practitioner shall be so notified and corrective action initiated. All rights and prerogatives authorized by Title 38 of the United States Code shall be accorded to the individual, including fair hearing and appellate review.

c. The duration of appointment of practitioners appointed by the Consultant/Attending or contract mechanism shall not exceed one year and shall automatically expire on the last day of the Federal Fiscal Year or the termination date of the contract. The appointment of practitioners appointed by the Fee Basis mechanism shall expire after one year. Appointment may be renewed after review of performance as described in subparagraph a. of this Section 1 and the needs of the Health Care System. Neither fair hearing or appeal rights are accorded upon denial of renewal of these types of appointment.

d. Reappraisal and reappointment to the Medical Staff shall occur every two years on the anniversary date of appointment.

4. MAINTENANCE OF CREDENTIALS RECORDS

A credentials file containing all relevant documents pertaining to each individual who applies for appointment shall be maintained in a fashion as prescribed by VHA Handbook 1100.19 – Credentialing and Privileging.

5. TEMPORARY APPOINTMENTS FOR URGENT PATIENT CARE, TREATMENT, OR SERVICES NEEDS

a. The Director, upon the recommendation of the Department Chief and the Chief of Staff, and with documentation of the specific urgent patient care situation or need that warrants such an appointment, may approve temporary appointment to the Medical Staff for licensed independent practitioners only.

b. Before temporary appointment can be approved, the practitioner shall submit a complete application, and his/her current license, medical staff/clinical privilege status, current competence, and one peer reference shall be verified, with no adverse information found. NPDB-HIPDB and FSMB query responses must be received, with no adverse matches or reports.

c. An application through VetPro shall be completed within three (3) calendar days of the date the appointment is effective. In addition to the minimum verifications listed, all remaining credentials shall be verified, even if completion occurs after the practitioner's temporary appointment is terminated or expires. If unfavorable information is discovered during the course of credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

d. Temporary appointments may not exceed forty-five (45) calendar days.

e. Temporary appointments may not be renewed or repeated.

6. EXPEDITED APPOINTMENTS

a. For those circumstances where it is determined that an expedited initial appointment of a license independent practitioner is in the best interest of quality patient care, a delegated subcommittee of the Executive Committee of the Medical Staff, consisting of at least two (2) members of XCOM, may recommended to the Director that appointment to the Medical Staff be granted.

b. For those applicants for whom there is evidence of a current or previously successful challenge to ANY credential or ANY current or previous administrative or judicial action, the expedited process CANNOT be used and complete credentialing must be accomplished for consideration in the usual manner by the Executive Committee of the Medical Staff.

c. Credentialing requirements for Expedited Appointments include:

(1) A complete application submitted through VetPro;

(2) Verification of the applicant's education and training;

(3) Verification of at least one active, current, unrestricted license;

(4) Confirmation by a physician of the applicant's physical and mental capability to fulfill the requirements of the clinical privileges being sought;

(5) Confirmation from at least two (2) peer references who are knowledgeable of and confirm the physician's competence and professional qualifications, including at least one reference from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges;

(6) Verification of current, comparable privileges held in another institution;

(7) Query of licensure history through the FSMB, with no report documented;

(8) Query of the National Practitioner Data Bank, with documentation of no match; and

(9) Verification of malpractice liability policy and claims histories.

d. If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted, and there is no history of malpractice payment, the expedited appointment may be recommended to the Director for approval.

e. Upon the Director's approval of an expedited appointment, completion of the full credentialing process shall occur within 30 calendar days, and shall include all remaining credentialing elements through VetPro.

f. The expedited appointment is a one-time process for initial appointment only and may not exceed forty-five (45) calendar days. It may not be extended or renewed.

g. Once the credentialing process is complete, all documents shall be presented to the Executive Committee of the Medical Staff for ratification within forty-five (45) calendar days of the expedited appointment. If not ratified within forty-five (45) calendar days, the appointment shall automatically be terminated. If ratified, the final effective date of the practitioner's appointment shall remain the original date of the expedited appointment.

J. CLINICAL PRIVILEGES

1. CLINICAL PRIVILEGES RESTRICTED

a. Every individual practicing independently at this Health Care System by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, have specifically delineated clinical privileges granted to him/her by the Director, appropriate to the site of care. This requirement shall be uniformly applied regardless of appointment mechanism.

b. Site of Care specific clinical privileges and the criteria to qualify therefore shall be formally developed in every department to which independent providers may be appointed and shall be reviewed and approved by the Executive Committee of the Medical Staff. All requests for clinical privileges shall be in writing, shall be signed by the applicant, shall be on a form prescribed by the Health Care System, and shall be submitted to the Chief(s) of the department(s) in which privileges are desired. Every individual permitted to practice independently must hold clinical privileges in the department to which appointed and may be granted privileges in other departments when so qualified.

c. Every initial application for appointment to the Medical Staff must be accompanied by a separate application for the specific clinical privileges desired by the applicant. The applicant shall be evaluated on such factors as education, training, documented experience, demonstrated current competence, health status, licensure and registration (including DEA), peer references, results of treatment, privileges held at other medical institutions, conclusions based on quality improvement data, and other relevant information, including an appraisal by the clinical department in which such privileges are sought. Professional sanctions shall also be considered. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

d. A detailed description of the requirements, process, and procedure for application for clinical privileges, criteria required, verification of credentials, forms prescribed and mechanisms for approval shall be maintained in a Credentialing and Privileging Manual approved by the XCOM and the Director. The contents and forms shall be modified by the XCOM as may, from time to time, be required. The Manual is herein incorporated into these Rules and Regulations by reference.

e. DENTISTS: Clinical privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists in the operating rooms of the Surgery Department shall be under the overall supervision of the Chief of the Surgery Department. All dental patients shall receive the same basic medical appraisal as patients admitted to other medical or surgical departments. Unless the dentist is also a physician, a physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The delineation and granting of clinical privileges for dentists shall be accomplished in a manner identical with the overall procedure established for the Medical Staff, including the rules of procedure for corrective action and the procedure for hearing and appellate review.

f. PODIATRISTS: Clinical privileges granted to podiatrists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief

of the Surgery Department. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The podiatrist is responsible for the podiatric care of the patient, including the podiatric history and physical examination and all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his/her license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. He/she shall agree to comply with all applicable Medical Staff Bylaws, Rules and Regulations and policies at the time of application for clinical privileges. The delineation and granting of clinical privileges for podiatrists shall be accomplished in a manner identical with the overall procedure established for the Medical Staff, including the rules of procedure for corrective action and the procedure for hearing and appellate review.

g. House Officers shall function within the graduated levels of their position description and the clinical privileges granted to their supervisors.

h. Admitting privileges are extended only to physician members of the Medical Staff appointed to the Medical, Surgical, or Mental Health and Behavioral Science Departments. Dentists, if they are also physicians, may admit patients.

i. Unrestricted clinical privileges at any Site of Care may not be granted to practitioners who:

(1) Require more than a thirty-minute drive to reach that site,

and

(2) Their physical presence may reasonably be required to meet the needs of patient(s) on a continuing basis.

j. Clinical privileges granted to Associated Health Personnel shall be governed by Department of Veterans Affairs regulations and Medical Staff Bylaws and Rules and Regulations and shall be based on the applicant's training, experience, and demonstrated competence and judgment. The delineation and granting of clinical privileges for such personnel shall be accomplished in a manner consistent with the overall procedures established for the Medical Staff as detailed, and the rules of procedure for corrective action, except that right to hearing and appeal applies only to those appointed under the provisions of Title 38 of the United State Code, Section 4104.

k. All clinical privileges shall expire no later than two years after the date of issuance unless otherwise renewed.

2. PROCESSING OF APPLICATIONS

a. The completed application for clinical privileges shall be submitted to the office of the Chief of the department in which privileges are requested. In collaboration with the Human Resource Management Service, an intensive review of the applicant's credentials shall be undertaken with a good faith effort to obtain primary source verification of all information submitted, including sanctions as described. A minimum of two inquiries shall be submitted to each primary source before presuming a response is not obtainable. Screening through the NPDB-HIPDB, the HHS OIG, and the FSMB, as described in **Section I.1.e.**, shall be included. The application and all supporting materials shall be forwarded to the Professional Standards Board with the written recommendations of the Department Chief for delineating the applicant's specified clinical privileges.

b. Normally, within thirty (30) days after receipt of the completed application for appointment and/or the request for clinical privileges, the Professional Standards Board shall make a written report of its deliberations. Prior to making this report, the Professional Standards Board shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant, and shall determine, through information contained in responses from references named by the applicant and from other sources available to the Board, whether the applicant has established and meets all of the necessary qualifications for eligibility for appointment in the Department of Veterans Affairs. After consideration of all pertinent information, the Professional Standards Board shall transmit to the Executive Committee of the Medical Staff a recommendation for the extent of clinical privileges to be granted if appointment is made.

c. At its next regular meeting after receipt of the recommendation of the Professional Standards Board, the Executive Committee of the Medical Staff shall either recommend to the Director the extent of clinical privileges which should be granted or defer the application for further consideration. All recommendations must specifically delineate the clinical conditions relating to such clinical privileges.

d. When the recommendation of the Executive Committee of the Medical Staff is to defer the application for further consideration, it must be reviewed within thirty (30) days with a subsequent recommendation as to specified clinical privileges should appointment be effected.

e. When the recommendation of the Executive Committee of the Medical Staff is favorable to the applicant, it shall be forwarded promptly to the Director.

f. When the recommendation of the Executive Committee of the Medical Staff is adverse to the applicant in respect to clinical privileges, the Chief of Staff shall promptly so notify the applicant and the Department Chief in writing. The notification shall indicate the specific privileges involved, the reasons therefore, and the alternatives available to the applicant, if any. Right to fair hearing and appellate review is not extended in instances of application for initial appointment or initial clinical privileges. No adverse recommendation shall be referred to the Director if the applicant accepts alternatives acceptable to the Executive Committee of the Medical Staff and he/she submits a revised request for clinical privileges.

g. If, after the Executive Committee of the Medical Staff has considered a revised request for clinical privileges, the Executive Committee of the Medical Staff's reconsidered recommendation is favorable to the practitioner, it shall be processed as described. If such recommendation continues to be adverse, the Chief of Staff shall promptly so notify the practitioner, in writing, and shall forward the recommendation to the Director.

h. After receipt of the recommendation of the Executive Committee of the Medical Staff, the Director shall act in the matter. The Director's decision shall be conclusive, except that he/she may defer final determination by referring the matter back to the Executive Committee of the Medical Staff for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Director shall be made, and may include a directive that additional information be developed to clarify issues which are in doubt. After receipt of such subsequent recommendation, and new evidence in the matter, if any, the Director shall make a decision as to the extent of clinical privileges to be extended to the applicant. All actions contained in this paragraph must be completed within forty-five (45) days.

i. Whenever the Director's decision will be contrary to the recommendation of the Executive Committee of the Medical Staff, the Director shall immediately submit the matter to a joint conference committee for review and recommendation and shall consider such recommendation before making his decision final. The joint conference committee shall consist of the Associate Director, the Chief of Staff, the Chief of the clinical department concerned, one at-large member of the Executive Committee of the Medical Staff, and one at-large member of the Medical Staff, and shall complete its deliberations within ten (10) days.

j. When the Director's decision is final, he/she shall send notice of such decision to the Chief of Staff, to the Department Chief concerned, and by official correspondence to the applicant or Medical Staff member.

k. The Director may act on credentials whenever the Medical Staff fails to act in accordance with the relevant requirements of these Rules and Regulations.

3. REAPPRAISAL AND RENEWAL OF CLINICAL PRIVILEGES

a. Periodic reappraisal of clinical privileges and the increase or curtailment of same shall be initiated upon application of the individual and shall be based upon the direct observation of care provided and documented experience and evidence of current competence, and shall occur at least every two (2) years. This shall include, but not be limited to: review of the care and results of treatment provided in this or other hospitals, additional training, certification, recommendations of peers, participation in continuing education, evidence of sound judgment, review of the records of the Medical Staff, evaluation of clinical skills as contained in results of performance improvement activities, and other pertinent information and documents. Current information concerning licensure and registration, as well as pending or actual limitation, reduction or loss of licensure, registration or medical staff status/clinical privileges at other hospitals, whether voluntary or involuntary in nature, shall also be evaluated. Professional liability actions during the evaluation period shall be examined.

b. A detailed specification of the requirements and process for reappraisal, modification, or renewal of privileges is contained in the Credentialing and Privileging Manual.

c. At the time of reappraisal of clinical privileges, the apparent physical and mental health of the practitioner, as determined by a physician, shall be indicated by his/her supervisor. Evaluation of health status shall follow regulations published by the Department of Veterans Affairs. In addition, the Department Chief, or Chief of Staff (in the case of reappraisal of a Department Chief), or the XCOM may request a special physical and/or mental examination at any time that the fitness for duty of any practitioner is in question. The Physical Standards Board, according to department of Veterans Affairs regulations, shall determine fitness for duty.

d. The Department Chief shall forward to the Executive Committee of the Medical Staff a recommendation that existing privileges be renewed or modified within thirty (30) days of receipt of the completed application and verification of its contents. In the event that modification results in a restriction of privileges previously held, the reason for such recommendation shall be stated and documented.

e. Within forty (40) days of receipt of the recommendations of the Department Chief, the Executive Committee of the Medical Staff shall make written recommendations to the Director concerning the clinical privileges of the individual practitioner under review. When a reduction or modification of clinical privileges is under consideration, the Chief of Staff shall give the affected practitioner prompt written notification. The notice shall indicate the specific privileges involved, the reasons therefore, and the practitioner's prerogative to review all pertinent documents not precluded by law or Department of Veterans Affairs regulation. Within ten (10) calendar days of notification, the affected

practitioner may submit a written response to the proposed adverse action that shall be reviewed by the Executive Committee of the Medical Staff at its next regularly scheduled meeting before arriving at a final recommendation. When reduction or modification of clinical privileges is recommended to the Director, the reasons for such recommendation(s) shall be stated and documented. Thereafter, the provisions of fair hearing and appellate review contained within these Rules and Regulations shall apply.

f. Unless the recommendation regarding reappointment by the Executive Committee of the Medical Staff is adverse, the procedures regarding notification as noted in these Rules and Regulations shall be followed.

4. TEMPORARY PRIVILEGES FOR URGENT PATIENT CARE, TREATMENT, OR SERVICE NEEDS

a. In the event of an urgent patient care, treatment, or service need, the Director, upon the recommendation of the Department Chief and the Chief of Staff, may grant temporary clinical privileges for licensed independent practitioners only, to coincide with the temporary appointment of that practitioner (see Section I.5.). Such privileges shall be based on a complete application and verification of a current license, medical staff/clinical privilege status, current competence, and one peer reference, with no adverse information found in any of these named verifications. NPDB-HIPDB and FSMB query responses must be received, with no adverse matches or reports.

b. Temporary privileges may not exceed forty-five (45) calendar days.

c. Temporary privileges may not be renewed or repeated.

d. In exercising such Temporary privileges, the applicant shall act under the supervision of the Department Chief to which he/she is assigned. The Department Chief may impose special requirements of supervision and reporting as he/she deems appropriate. Temporary privileges shall be immediately terminated by the Director upon notice of any failure by the practitioner to comply with such special conditions.

e. The Director may at any time, upon the recommendation of the Chief of Staff or Department Chief concerned, terminate a practitioner's temporary privileges. The appropriate Department Chief or, in his/her absence, the Chief of Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the Health Care System.

5. EXPEDITED PRIVILEGES

a. In the event the Director approves an Expedited Appointment for a licensed independent practitioner (see Section I.6.), clinical privileges shall be approved simultaneously through the same process.

b. The Expedited Appointment is a one-time process for initial appointment only and appointment and privileges may not exceed forty-five (45) calendar days. They may not be extended or renewed.

c. Once the credentialing process is complete, all documents, including requests for clinical privileges, shall be presented to the Executive Committee of the Medical Staff for ratification within forty-five (45) calendar days of the expedited appointment. If not ratified within forty-five (45) calendar days, the appointment and privileges shall automatically be terminated. If ratified, the final effective date of the practitioner's appointment and privileges shall remain the original date of the expedited appointment.

6. EMERGENCY PRIVILEGES

In the case of emergency, any physician or dentist member of the Medical Staff with delineated clinical privileges, to the degree permitted by his/her license and regardless of department, staff status or clinical privileges, shall be permitted and assisted to do everything possible to save the life of or to prevent serious harm to, a patient, using every facility of the Health Care System necessary, including the calling of any consultation necessary or desirable. For the purpose of this section, an "emergency" is defined as a condition in which serious harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

7. DISASTER PRIVILEGES

In the event the Health Care System's Emergency Management Plan is activated, and if assistance from non-VA licensed independent practitioner(s) is necessary to handle all immediate patient care needs, disaster clinical privileges may be granted by the Director or the Chief of Staff, or designee, on a case-by-case basis and at his/her discretion, following the guidelines listed below.

a. Disaster privileges may be granted to licensed independent practitioner(s) upon presentation of any of the following:

(1) Current picture hospital ID card AND evidence of current appropriate licensure.

(2) Valid picture ID issued by a state, federal, or regulatory agency AND evidence of current appropriate licensure.

(3) Identification indicating that the individual is a current member of a Disaster Medical Assistance Team (DMAT).

(4) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).

(5) Personal attestation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity and his/her qualifications and competence.

b. The National Practitioner Data Bank, HHS OIG, and FSMB shall be queried as soon as feasible.

c. Primary source verification of individual licensure shall begin as soon as feasible and shall be completed within 72 hours from the time each volunteer practitioner presents to the Health Care System.

d. The practitioner may be paired with a currently privileged member of the Medical Staff and may be requested to act only under his/her direct supervision.

e. Following review of verified credentials and all available professional practice information, a decision regarding continuation of disaster privileges granted to each volunteer practitioner shall be made within 72 hours from the time that practitioner presents to the Health Care System. However, the Director or the Chief of Staff may, at his/her discretion, terminate a volunteer practitioner's disaster privileges at any time without reason or cause. The practitioner shall have no rights to a hearing or review in the event of termination of his/her disaster privileges.

f. Duration of disaster privileges may not exceed ten (10) calendar days or the length of the declared disaster or emergency situation, whichever is shorter. If necessary, at the end of this 10-day period, the practitioner's privileges may be converted to Temporary privileges as defined in these Bylaws.

g. Upon termination of the disaster, or as soon as feasible following the granting of disaster privileges, the practitioner shall submit a complete application and full credentialing shall be accomplished in order to determine if any follow-up is required.

8. MAINTENANCE OF CREDENTIALS RECORDS

A credentials file containing all relevant documents pertaining to each individual who applies for clinical privileges shall be maintained in a fashion as prescribed by VHA Handbook 1100.19 – Credentialing and Privileging.

K. CORRECTIVE ACTION

1. PROCEDURE

a. Whenever the activities or professional conduct of any individual with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, or to be disruptive to the operations of the Health Care System, corrective action against such individual may be requested. Such action shall follow prescribed Department of Veterans Affairs regulations relevant to disciplinary action, suspension or termination. Notwithstanding, it is the right of the Department Chief or, in the case of a Department Chief, the Chief of Staff, at any time to review and, if necessary, to recommend remedial action such as counseling, continuing education, special training, or changes in the clinical privileges of any staff member. In determining appropriate action, the Chief of Staff may seek the assistance of the Professional Standards Board in reviewing any/all cases. Such action shall be made known to the individual in writing. Staff members or Associated Health Personnel appointed under authority of 38 United States Code, Section 4104, may contest the recommendation to the Executive Committee of the Medical Staff in writing within ten (10) calendar days of notification of proposed adverse action. After review, the Executive Committee of the Medical Staff shall make recommendations to the Director for implementation. Any recommendation by the Executive Committee of the Medical Staff for reduction, suspension or revocation of clinical privileges, shall entitle the affected practitioner or those Associated Health Personnel appointed under authority of 38 United States Code, Section 4104, to the procedural rights provided in these Bylaws. However, when the performance of a member of the Staff is such that, in the opinion of the Department Chief or the Chief of Staff in the case of a Department Chief, his/her continued exercise of clinical privileges would likely lead to serious harm to the patients under his/her care, any or all privileges may be summarily suspended. The Director shall notify the affected individual of this action in writing. Such suspension of clinical privileges shall be considered temporary and the affected individual shall be entitled to the procedural rights under the Bylaws before a permanent decision is made. During the period of suspension of privileges, the Department Chief shall arrange for another staff member to assume care of patients assigned to the affected practitioner.

b. Automatic revocation of clinical privileges shall occur whenever the license (or equal legal credential) of a practitioner or Associated Health Personnel is revoked or restricted. Clinical privileges shall be automatically suspended for the same period that the license (or equal legal credential) of a practitioner or Associated Health Personnel is suspended. No right to hearing or appeal exists under these conditions.

c. Whenever a Drug Enforcement Administration (DEA) registration is revoked or suspended, the practitioner immediately and automatically is divested of his/her right to prescribe medications covered by the number. Right to fair hearing and appeal does not apply to this circumstance.

d. The Executive Committee of the Medical Staff may develop policies of automatic temporary suspension of clinical privileges for failure to complete medical records in a timely fashion.

e. Failure of a practitioner to permit house staff to write orders on his/her patients or to participate in teaching programs shall not be grounds for corrective action.

2. REPORTS OF ADVERSE ACTION

a. The Professional Standards Board, upon the request of the Chief of Staff, shall review all cases involving adverse actions and/or potential reporting of a health care practitioner to the National Practitioner Data Bank (NPDB).

b. After all rights provided in the Bylaws are deemed to be exhausted or waived, and all rights accorded by Federal Law and VA Regulations have been extended, the Director shall report adverse actions as required from time to time by VA policy.

c. Information regarding practitioners or others with clinical privileges separated from VA service for cause related to professional performance shall be reported to relevant State Licensing Boards.

d. Adverse action against clinical privileges shall be reported to the NPDB and the appropriate State Licensing Board(s).

e. Professional liability payments on the part of the U.S. Government on behalf of a practitioner because of incompetence or misconduct as determined by peer review, shall be reported to the NPDB as determined by the DVA review.

3. TERMINATION

Termination of Medical Staff appointment shall be in accordance with VA Regulations.

4. DENIAL OF APPOINTMENT

Individuals, qualified for membership as described, who are denied appointment to the Medical Staff, shall be so informed in writing along with the reasons therefore. Applicable Federal Statute shall govern appeals of such denial.

L. HEARING AND APPELLATE REVIEW PROCEDURE

1. RIGHT TO HEARING AND TO APPELLATE REVIEW

a. When the Executive Committee of the Medical Staff recommends revocation of all clinical privileges, if ratified by the Director, simultaneous and parallel action shall be initiated to terminate the appointment of the individual involved. Department of Veterans Affairs regulations regarding separation shall apply, including all rights of notification, hearing, access to relevant documents, representation, and appeal.

b. When any practitioner or Associated Health Personnel appointed under authority of Title 38, United State Code, Section 4104, receives notice of a recommendation by the Executive Committee of the Medical Staff that, if ratified by decision of the Director, shall result in reduction or modification of his/her clinical privileges, he/she shall be entitled to submit a written response. If the recommendation of the Executive Committee of the Medical Staff, following review of the response, is still adverse, or if no written response is submitted, the Director shall review the record and make a decision.

c. When an individual receives notice of a decision by the Director that will result in reduction or modification of his/her clinical privileges, he/she shall be entitled to one of the following as he/she chooses:

(1) A hearing by a committee appointed by the Director. If the hearing does not result in a decision by the Director with which the individual agrees, he/she may request an appellate review by the Network Director.

(2) If the individual does not request an initial hearing with a committee appointed by the Director, he/she may request an appellate review by the Network Director.

d. All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth to assure that the affected individual is accorded all rights to which he/she is entitled.

2. REQUEST FOR HEARING

a. The Director or Chief of Staff, as appropriate, shall be responsible for giving prompt written notice of an adverse recommendation or decision to any affected individual who is entitled to submit a written response, or to a hearing, or to an appellate review by official correspondence.

b. The failure of an individual to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner herein provided, shall be deemed a waiver of his/her right to such hearing and to any directly related appellate review which might have followed the hearing. The failure of an individual to request an appellate review by the Network Director to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such appellate review on the matter.

c. When the waived appellate review relates to an adverse decision by the Director based on the record after the right of the individual to a hearing was waived, OR when the waived appellate review relates to an adverse decision by the Director after the report of a hearing committee appointed by the Director, the identical effect shall result. The adverse decision shall become and remain effective against the individual in the same manner as a final decision of the Network Director. The affected individual shall be promptly notified of his/her status by official correspondence.

3. NOTICE OF HEARING

a. Generally within ten (10) days of notice of potential reduction/modification of privileges, the individual may submit a written response to the Chief of Staff for review by the Executive Committee of the Medical Staff. The review shall be conducted generally within ten (10) days of receipt of the response. The notice shall inform the individual of his/her right to representation by counsel or representative of his/her choice, as well as the right to review all evidence not restricted by federal regulation or statute upon which proposed changes are based.

b. Within five (5) workdays after receipt of a request for hearing from a practitioner entitled to the same, the Director shall schedule and arrange for such a hearing and shall notify the individual of the scheduled time, place, and date by official correspondence. The hearing, including a report, shall generally be completed within fifteen (15) workdays after authorization by the Director and in all instances by thirty (30) workdays.

c. The notice of potentially adverse recommendation, or of the hearing, shall state in concise language the specific privileges under consideration, a list of specific or representative medical records being questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.

4. COMPOSITION OF HEARING COMMITTEE

When a hearing relates to an adverse decision by the Director, such hearing shall be conducted by an ad hoc hearing committee of not fewer than three (3) members appointed by the Director, one (1) of whom shall be designated as chairman. At least two (2) of the members shall be of the same profession as the individual involved, and one (1) shall be a member of the Medical Staff. No one who has actively participated in the consideration of an adverse recommendation shall be appointed a member of this hearing committee unless it is otherwise impossible to select a representative group.

5. CONDUCT OF HEARING

a. There shall be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

b. An accurate record of the hearing shall be kept. The mechanism shall be established by the ad hoc hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, and detailed transcription or by the taking of adequate minutes.

c. The personal presence of the individual for whom the hearing has been scheduled shall be permitted. An individual who fails without good cause to participate and/or cooperate with such hearing shall be deemed to have waived his/her rights.

d. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the Director in consultation with the ad hoc hearing committee. Granting of such postponements shall only be for good cause shown and is the sole discretion of the Director.

e. The affected individual shall be entitled to be accompanied by and/or represented at the hearing by counsel or a representative of the individual's choice.

f. The chairman of the hearing committee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

g. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered regardless of the existence of any common law or statutory rule, which might make evidence inadmissible over objection in civil or criminal action. The individual for whom the hearing is being held shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record.

h. In reaching a decision, official notice may be taken by the hearing committee, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of the State where the hearing is held or the United States. Participants in the hearing shall be informed of the matters to be noticed and those matters shall be noted in the record of the hearing. The individual for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider any pertinent material not restricted by Department of Veterans Affairs Regulation or Statute, contained on file in the Health Care System, as well as all other information which can be considered in connection with applications for appointment to the Medical Staff and for clinical privileges pursuant to these Bylaws.

i. The affected individual shall have the following rights: to examine all evidence not restricted by Regulation (Federal or Department of Veterans Affairs) or Statute, to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any matter relevant to the issue of the hearing, to challenge any witness and to rebut any evidence. However, patients may not be called as witnesses unless they are willing to testify voluntarily. If the individual does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

j. The hearing committee may order that oral evidence be taken only on oath or affirmation administered by any person entitled to notarize documents in the State of Nebraska.

k. The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the individual for whom the hearing was convened.

l. The hearing committee shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the Director. The report may recommend confirmation, modification, or rejection of the original decision of the Director. The Director, thereafter, may accept, reject, or modify, in whole or in part, the hearing committee's recommendations.

6. FINAL DECISION BY THE DIRECTOR

a. Within ten (10) workdays of receipt of the hearing committee's written report, its recommendation, and the hearing record and all pertinent documentation, the Director shall issue a written decision based on the record. If the individual's privileges are reduced or modified, the written decision shall indicate the reasons therefore. If the individual chooses not to request a hearing or to appeal to the Network Director, the Director's decision shall be final.

7. APPEALS TO THE NETWORK DIRECTOR

a. Within five (5) workdays after receipt by an affected individual of an adverse decision by the Director, with or without a hearing, he/she may, by written notice to the Network Director, request an appellate review.

b. The appellate review shall be held only on the record on which the adverse decision is based.

c. In the absence of compelling reasons, if such appellate review is not requested within five (5) days, the affected individual shall be deemed to have waived his/her right to the same, and to have accepted the adverse decision.

8. FINAL DECISION BY THE NETWORK DIRECTOR

a. Within twenty (20) workdays after the request for an appellate review, the Network Director shall provide a written decision in the matter and shall send notice thereof to the Health Care System Director and to the affected individual by official correspondence.

b. Notwithstanding any other provision of these Bylaws, no individual shall be entitled as a right to more than one (1) hearing and one (1) appellate review on any given matter that shall have been the subject of action by the Director.

## RULES AND REGULATIONS OF THE MEDICAL STAFF

ADOPTED as amended by the Executive Committee of the Medical Staff on February 14, 2007.

ROWEN K. ZETTERMAN, M.D.
Chief of Staff

APPROVED by the Medical Center Director on February 14, 2007.

AL WASHKO
Director