BYLAWS AND RULES OF THE MEDICAL STAFF
OF
VETERANS HEALTH ADMINISTRATION (VHA)

VA Long Beach Healthcare System

Long Beach, California

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PREAMBLE *

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the VA Long Beach Healthcare System in Long Beach, California (hereinafter sometimes referred to as VALBHS, HS, Facility, or Organization) hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs, Veterans Health Administration (VHA), and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the VHA, and they do not create any rights or liabilities not otherwise provided for in laws or VHA Regulations. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

VA Long Beach Healthcare System is comprised of the VA Long Beach Medical Center (providing comprehensive health care through primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, neurology, oncology, dentistry, spinal cord injury, physical medicine and rehabilitation, geriatrics, extended care, and VA Center of Excellence for Stress & Mental Health, Mental Illness Rehabilitation, Education, and Clinical Centers (MIRECC), a Spinal Cord Injury & Disorder Center, Blind Rehabilitation Center, two Veteran Centers (Garden Grove and Mission Viejo) and five Community Based Outpatient Clinics (CBOCs) located in Anaheim, Santa Ana, Villages at Cabrillo in Long Beach, Laguna Hills and Whittier -Santa Fe Springs.

Decisions regarding the appointment to the Medical Staff and the granting of clinical privileges are made without discrimination for reasons such as race, color, religion, national origin, gender, sexual orientation, lawful partisan political affiliation, marital status, physical or mental handicap when the individual is qualified to do the work, age, membership or non-membership in a labor organization, or on the basis of any other criteria unrelated to professional qualifications.

Portions of these bylaws are required by VA, VHA, or The Joint Commission (TJC). These sections should be maintained in accordance with all current regulations, standards or other applicable requirements. Prior versions of bylaws and rules and regulations must be maintained in accordance with Sarbanes-Oxley Act which states that bylaws and rules are permanent records and should never be destroyed. They must be maintained in accordance with Record Control System (RCS) 10-1, 10Q.

DEFINITIONS

For the purpose of these Bylaws, the following definitions shall be used:

1. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, Mid-level and/or patient

care services at the facility. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.

2. Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when serving in the capacity of Acting Facility Director.

3. Associated Health Professional: As used in this document, the term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine. These professionals include, but are not limited to: Clinical Pharmacy Specialists (Pharmacists/PharmDs), psychologists, podiatrists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.

4. Automatic Suspension of Privileges: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation of clinical care concerns. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care, conduct/behavior issues not impacting patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Medical Executive Council (MEC).

5. Chief of Staff: The Chief of Staff is the President of the medical staff and Chairperson of the MEC and acts as full assistant to the Director in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioners, Mid-level Practitioners, and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of medical staff.

6. Community Based Outpatient Clinic (CBOC): A health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients. A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures

7. Credential & Privileging Committee: The Credential & Privileging Committee acts on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matter to the Medical Executive Council as defined in these Bylaws. The Credential & Privileging Committee acts on behalf of the MEC to recommend Medical Staff appointments to the HS Director. The Credential & Privileging Committee also may act as the Professional Standards Board as necessary.

8. Dean's Committee: The term "Dean's Committee" means the committee composed of department chairs of the Medical School, Chiefs of the counterpart Healthcare Group (HCG) at VALBHS, and members of the VA Medical Staff nominated by the

Dean of the affiliated Medical School (i.e., University of California, Irvine) and appointed by the Director of this HS. This group functions as an advisory council to the HS Director on matters related to undergraduate and graduate medical education, research activities, and credentialing of new applicants to membership of the Medical Staff

9. Director (or Facility Director): The Director is appointed as the Governing Body to act as its agent in the overall management of VALBHS. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services/Nurse Executive (AD-PCS/NE), and the Medical Executive Council

10. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the Facility Director. The Director is responsible for the oversight and delivery of health care by all employees and specifically including the medical staff credentialed and privileged by the relevant administrative offices and facility approved processes.

11. Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the VALBHS to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians, dentists, podiatrists, optometrists, chiropractors and doctoral-level psychologists. It may also include individuals who can practice independently, who meet this criterion for independent practice

12. Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the medical staff process who are subject to the medical staff bylaws. The medical staff includes both members of the organized medical staff and non-members of the organized medical staff who provide health care services.

13. Nurse Executive (AD-PCS/NE): The Nurse Executive is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he is the Chairperson of the Nurse Executive Council (NEC) and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant mid-level and certain associated health staff and in ensuring the ongoing education of the nursing staff.

14. Organized Medical Staff: The body of Licensed Independent Practitioners who are collectively responsible for adopting and amending medical staff bylaws (i.e., those with voting privileges as determined by the Facility as defined in these Bylaws) and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges.

15. Outpatient Clinic: An outpatient clinic is a healthcare site whose location is independent of medical facility, however; oversight is assigned to a medical facility.
16. Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner-specific data collected from various sources for the purpose of evaluating current competence.
17. Primary Source Verification: Documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care Practitioner. This can be a letter, documented telephone contact, or secure electronic communication with the original source.
18. Privileges. The use of "privileges" throughout this document refers to either clinical privileges or scope of practice as appropriate to the type of practitioner.
19. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.
20. Rules: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the bylaws. They can be reviewed and revised by the MEC and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.
21. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider
22. Telemedicine: The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.
23. VA Regulations: The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws. (Example: Code of Federal Regulation (CFR) 38 7402)

ARTICLE I. **NAME**

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, Long Beach Healthcare System.

ARTICLE II. **PURPOSE**

The purposes of the Medical Staff shall be to

1. Assure a well functioning relationship between the medical staff and the governing body. This function is accomplished by the Chief of Staff serving as the chair of the Medical Executive committee and as a member of senior leadership staff who reports to the governing body.
2. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
3. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.
4. Establish and assure adherence to ethical standards of professional practice and conduct.
5. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
6. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
7. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
8. Develop the medical staff bylaws, rules and regulations and policies.
9. Provide a medical perspective, as appropriate, to issues being considered by the Director and Governing Body including any major management decisions affecting patient care, teaching, and research at VALBHS.
10. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.
11. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.
12. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
13. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.
14. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational publications.

ARTICLE III. **MEDICAL STAFF MEMBERSHIP ***

Section 3.01 Eligibility for Membership on the Medical Staff *

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians and dentists, podiatrists, optometrists, chiropractors and psychologists who continuously meet the qualifications, standards, and requirements of VHA, this Facility, and these Bylaws. For the majority of the Medical Staff, an employer/employee relationship, either with or without compensation, will be an integral part of staff membership. Properly appointed consulting attending and on station fee-basis physicians are considered to be in a class of individuals covered by the provisions of the Federal Tort Claims Act, but are not otherwise seen as employees.

2. Categories of the Medical Staff: There shall be one category of Medical Staff membership, active. All medical care, including the admissions, evaluation, and "emergency" functions of the hospital, will be carried out by members of this category, assisted as appropriate by designated professional personnel subject to the supervision of the staff. All members of the Staff, regardless of membership, shall be assigned to a specific clinical section within a HCG which will recommend appropriate privileges for the member and in whose meetings and performance improvement activities the member will participate, as stipulated in Article IX of these Bylaws and Rules ("Health Care Groups"). Physicians and practitioners seeking to exercise privileges in more than one service will be required to apply for such additional privileges through the respective HCG, as described in Article V of these Bylaws and Rules ("Clinical Privileges "). Only active Medical Staff members who serve 5/8th time or more shall have the right to vote.

   a. Active Staff shall consist of physicians, dentists, optometrists, podiatrists, chiropractors and psychologists, employed under Title 38 USC, who are professionally responsible for specific patient care, education, and/or research activities of the HS, and who assume all the functions and responsibilities of membership on the active staff. A member of the active staff shall:

      i) Retain responsibility within his or her area of professional competence for the daily care and supervision of each patient for whom he or she is providing service, or arrange a suitable alternate for such care and supervision, and exercise such clinical privileges as have been granted.

      ii) Actively participate in peer review, patient care evaluation, and other performance improvement activities required of the staff, and discharge such staff functions as may be required from time to time.

      iii) Assume responsibility for the supervision of house officers and other non-Medical Staff professionals as may be required.

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges *

1. Criteria for Clinical Privileges: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Privileging criteria are further detailed in

VHA Handbook 1100.19. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial.

a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required by VA employment and utilization policies and procedures.

b. Education applicable to individual Medical Staff members as defined, for example holding a Doctorol level degree in Medicine, Osteopathy, or Dentistry from an approved college or university.

c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training. Candidates must affirm that privileges requested are within the scope of their current competency.

d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying. This includes internships, residencies, board certification or specialty training. Candidates must affirm that privileges requested are within the scope of their current competency.

e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.

f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VI or VII or of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff. Candidates must reveal if, at any time, they have had clinical privileges and/or membership denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished, or voluntary or involuntary changes in Medical Staff membership at another hospital.

g. Satisfactory findings relative to previous professional competence and professional conduct. Candidates must agree to disclose any history of malpractice actions or settlements as well as charges brought against them by licensing boards, Drug Enforcement Administration (DEA), or regulatory agencies.

h. Is a citizen or a permanent resident of the United States. Non-citizens will be considered (in accordance with DVA/VHA regulations) only when no U.S. citizens are available.

i. English language proficiency.

j. Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.

k. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver’s license or passport)

2. Clinical Privileges and Scope of Practice: While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent Practitioners are permitted by this Facility and these Bylaws to practice independently. All Practitioners listed below are subject to the bylaws whether they are granted defined clinical privileges or not.

   a. The following Practitioners will be credentialed and privileged to practice independently:

      i) Physicians

      ii) Dentists

   b. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:

      i) Psychologists (Doctoral level)

      ii) Optometrists

      iii) Podiatrists

      iv) Chiropractors

   c. The following Practitioners will be credentialed and will practice under a Scope of Practice with appropriate supervision:

      i) Physician Assistants.

3. Change in Status: Members of the Medical Staff as well as all Practitioners practicing through privileges or a scope of practice must agree to provide care to patients within the scope of their Delineated Clinical Privileges or Scope of Practice and advise the Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges which are held, and any changes in the status of professional credentials, such as, but not limited to, loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society as soon as able, but no longer than 15 days after notification of the practitioner.

Section 3.03 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 3.04: Conflict Resolution & Management

For VA to be effective and efficient in achieving its goals we must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program,* addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. This mechanism can be utilized to manage conflict between the Executive Committee and the Organized Medical Staff on issues including, but not limited to proposals to adopt a rule or regulation or policy or amendment thereto. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Governing Body (Director) on a rule, regulation or policy adopted by the Organized Medical Staff or the Executive Committee. VHA expects VA medical center leadership to make use of these and other resources in communicating expectations to clinicians and other staff that conflictive, disruptive, inappropriate, intimidating, and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff who experience or witness such behavior are encouraged to advise an appropriate supervisor or Patient Safety Officer.

ARTICLE IV: ORGANIZATION OF THE MEDICAL STAFF *

Section 4.01 Leaders *

1. Composition: The only officer of the Medical Staff is the Chief of Staff. The Department of Veterans Affairs has no provision for elected "officers" of the Medical Staff.

   a. Chief of Staff.

      i) Selection: The Chief of Staff is appointed by the VISN Director upon the recommendation of the HS Director.

      ii) Duties:

         (1) Aid in coordinating the activities of the HS administration and of non-physician patient care services with those of the medical and nursing staff.

(2) Be accountable to the HS Director, in conjunction with the MEC, for the quality and efficiency of clinical services and for the overall professional performance within the HS.

(3) Develop and implement, in cooperation with the clinical HCG chiefs, methods for credentials review and for delineation of privileges, continuing professional education programs, utilization review, and concurrent monitoring of practice.

(4) Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the HS Director and other officials of the DVA.

(5) Be responsible for the enforcement of the Bylaws and Rules of the Medical Staff.

(6) Chair the Medical Executive Council. A designee may also perform this function.

(7) Call, preside over, and prepare the agenda of the general meetings of the Medical Staff.

(8) Ensure, assisted by the ACOS of Research HCG, that all research authorized at the HS is of an acceptable caliber and that the rights of research subjects are fully protected at all times.

(9) Promote the education mission and the academic performance of the HS assisted by the ACOS for Educational Resources and Affiliations.

(10) Appoint an Associate Chief of Staff for Clinical Affairs with the concurrence of the Medical Staff

iii) Removal: Although the Chief of Staff is not an elected officer, he or she may be removed through the processes described in VHA Directives and supplements thereto, consistent with these Bylaws. 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. The Medical Staff may participate in the decision to remove the Chief of Staff by recommending removal to the Director as a result of violation of these Bylaws or other action that results in the Chief of Staff's loss of privileges and/or membership in the Medical Staff. Questions or concerns about removal procedures should be directed to the Veterans Integrated Service Network Director (VISN), and/or the Chief Network Officer, Headquarters, Washington, DC, and/or the Office of the Regional Counsel.

b. ACOS, Research

i) Selection: The ACOS, Research, is appointed by the Chief of Staff with the concurrence of the Dean's Committee after a formal search consistent with Equal Employment Opportunity requirements.

ii) Duties: Assist the Chief of Staff by ensuring that all research authorized at the HS is of an acceptable caliber and that the rights of research subjects are fully protected at all times

c. ACOS, Educational Resources & Affiliations

i) Selection: The ACOS, Educational Resources & Affiliations, is appointed by the Chief of Staff.

ii) Duties: Assist the Chief of Staff by promoting the education mission and the academic performance of the HS.

Section 4.02 Leadership

1. The Organized Medical Staff, through its committees and Health Care Group Chiefs, provides counsel and assistance to the Chief of Staff and Director regarding all facets of patient care, treatment, and services including evaluating and improving the quality and safety of patient care services.

Section 4.03 Clinical Health Care Groups *

1. Characteristics: *

a. Clinical Health Care Groups (HCG) are organized to provide clinical care and treatment under leadership of a HCG Chief.

b. HCGs hold service-level meetings at least quarterly.

2. Functions: *

a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety, (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; patient safety and risk management activities; and utilization management.

b. Assist in identification of important aspects of care for the Service, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities.

c. Maintain records of meetings that include reports of conclusions, data, recommendations, responsible person, actions taken, and an evaluation of effectiveness of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on a quarterly basis.

d. Develop criteria for recommending clinical privileges for members of the Service and ensure that ongoing professional practice evaluation is continuously performed and results are utilized at the time of re-privileging.

e. Define and/or develop clinical privilege statements including levels (or categories) of care that include all requirements of VHA Handbook 1100.19.

f. Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within the Service.

g. Annually review privilege templates for each Service and make recommendations to MEC..

3. Selection and Appointment of HCG Chiefs: * HCG Chiefs are appointed by the HS Director based upon the recommendation of the Chief of Staff. The removal/reassignment of HCG Chiefs is at the discretion of the Governing Body according to VHA guidelines.

   a. Criteria for appointment as HCG Chief include Board Certification/or equivalent experience and comparable training as vetted through the credentialing process.

   b. The performance of chiefs of the clinical HCGs shall be evaluated on an annual basis by the Chief of Staff and may include input from members of the respective HCG and may be based on professional criteria that include clinical, administrative, education, research, and leadership capabilities.

4. Duties and Responsibilities of HCG Chiefs: * The HCG Physician Chief is administratively responsible for the operation of the HCG and its clinical and research efforts, as appropriate. In addition to duties listed below, the HCG Physician Chief is responsible for assuring the HCG performs according to applicable VHA performance standards. These are the performance requirements applicable to the HCG from the national performance contract, and cascade from the overarching requirements delegated to the Chief of Staff. These requirements are described in individual Performance Plans for each HCG Physician Chief. HCG Physician Chiefs are responsible and accountable for:

   a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as HCG Chief.

   b. Clinically related activities of the HCG.

   c. Administratively related activities of the department, unless otherwise provided by the organization.

   d. Continued surveillance of the professional performance of all individuals in the HCG who have delineated clinical privileges through FPPE/OPPE.

   e. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the HCG.

   f. Recommending clinical privileges for each member of the HCG.

g. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the HCG and communicating the recommendations to the relevant organizational authority.

h. The integration of the HCG into the primary functions of the organization.

i. The coordination and integration of interdepartmental and intradepartmental services.

j. The development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.

k. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.

l. The determination of the qualifications and competence of HCG personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services.

m. The continuous assessment and improvement of the quality of care, treatment, and services.

n. The maintenance of and contribution to quality control programs, as appropriate.

o. The orientation and continuing education of all persons in the HCG.

p. The assurance of space and other resources necessary for the services defined to be provided for the patients served.

q. Annual review of all clinical privilege forms to ensure that they correctly and adequately reflect the services being provided at the facility. This review is noted by date of review being included on the bottom of each privilege delineation form.

r. Communicate in writing to all Medical Staff under his/her supervision their role and responsibility during a disaster. The communication should detail expected actions and reporting structure during a disaster event.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.
2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.
3. The presence of the majority of a committee's voting members will constitute a quorum, unless otherwise specified in the committee’s charter.
4. The members of all standing committees, other than the MEC, are appointed by the Chief of Staff subject to approval by the MEC, unless otherwise stated in these Bylaws.

5. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff.
6. Robert's Rules of Order will govern all committee meetings.

Section 5.02 Executive Committee of the Medical Staff *

1. Characteristics: The Medical Executive Council (MEC) serves as the Executive Committee of the Medical Staff. MEC shall be the major forum for communication with the Medical Staff at large and provide counsel and assistance to the Chief of Staff and to the HS Director regarding all facets of the patient care service programs, including continuous performance improvement, goals and plans, mission and services offered. Members of the Medical Executive Council * are identified in the Medical Executive Council Charter found on Docushare at : http://vaww.docushare.visn22.med.va.gov/dsweb/View/Collection-6642

   a. Other facility staff as may be called upon to serve as resources or attend committee meetings at the request of the chairperson, with or without vote (as determined by the MEC, as appropriate). For example, a Physician Assistant may be called to be present when an action affecting another Physician Assistant is being considered. Any member of the Medical Staff (with or without vote) is eligible for consideration.

   b. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

   c. Changes to the MEC membership, leadership, and authority to act may be made by the Medical Staff and proposed directly to the Director. To do so apart from the recommendation of the COS and the MEC, a majority of the Medical Staff voting members must vote to make a change. This may be done, for example, by petition, electronic voting, or at a meeting of the Medical Staff in which a majority of all voting members of the Medical Staff is present. The COS or a representative of the Medical Staff must communicate in writing to the Director the outcome of the Medical Staff decision whether the decision is to adopt or vote down the proposed change in MEC membership, leadership, and authority to act. If adopted, the Director is the final approving authority. The Director will give written notice of the decision to the Medical Staff.

   d. Functions of the MEC:*The specific charges of the MEC are:

   e. Acts on behalf of the Medical Staff between Medical Staff meetings within the scope of its responsibilities as defined by the Organized Medical Staff.

   f. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process in support of clinical privileges and/or scope of practice requested; to address the scope and quality of services provided within the facility.

   g. Acts to ensure effective communications between the Medical Staff and the Director.

   h. Makes recommendations directly to the Director regarding the:

i) Organization, membership (to include termination), structure, and function of the Medical Staff.

ii) Process used to review credentials and delineate privileges for the medical staff.

iii) Delineation of privileges for each Practitioner credentialed.

i. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant internal/external standards**.**

j. Oversees process in place for instances of "for-cause" concerning a medical staff member's competency to perform requested privileges.

k. Oversees process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.

l. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.

m. Monitors medical staff ethics and self-governance actions.

n. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.

o. Receives and acts on reports and recommendations from medical staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body.

p. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.

q. Acts upon recommendations from the Credentialing & Privileging Committee.

r. Acts as and carries out the function of the Physical Standards Board, which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician. The Physical Standards Board may have the same membership as the local physician Professional Standards Board or members may be designated for this purpose by the health care facility Director. Boards may be conducted at other VA healthcare facilities.

s. Provides oversight and guidance for fee basis/contractual services.

t. Annually reviews and makes recommendations for approval of the HCG-specific privilege lists.

2. Meetings:

a. Regular Meetings: Regular meetings of the MEC shall be held at least ten times per year. The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chairmen of the various committees of the Medical Staff shall attend regular

meetings of the MEC when necessary to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the MEC.

b. Emergency Meetings: Emergency meetings of the MEC may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the MEC, the Director as the Governing Body or Acting Chief of Staff, acting for the Chief of Staff, may call an emergency meeting of the Committee.

c. Meeting Notice: All MEC members shall be provided at least two weeks advance written notice of the time, date, and place of each regular meeting and reasonable notice, oral or written, of each emergency meeting.

d. Agenda: The Chief of Staff, or in his absence, such other person as provided by these Bylaws, shall chair meetings of the MEC. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.

e. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the MEC shall be a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

f. Minutes: Written minutes shall be made and kept on all meetings of the MEC, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff.

g. Communication of Action: The Chair at a meeting of the MEC at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.

Section 5.03 Committees of the Medical Staff

The Standing Committees of the Medical Staff are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Mid-Level and Associated health Practitioners (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners and (g) for such additional purposes as may be set forth in the charges to each committee: The specific charges and membership of the Committees are set forth in their respective Charters found on Docushare: http://vaww.docushare.visn22.med.va.gov/dsweb/View/Collection-6755

1. Information Flow to MEC. All MEC committees shall develop a charter. All charters shall be forwarded to the parent board/council for approval and to the Chief of Staff and HS Director for final approval. All MEC committees will submit quarterly reports and any other reports or documents as required and/or requested by the MEC.

Section 5.04 Committee Records and Minutes

1. The quorum shall be the majority of voting members present unless otherwise specified in their Charter
2. Committees prepare and maintain reports to include data, conclusions, recommendations, responsible person, actions taken, and evaluation of results of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on a quarterly basis.
3. Each Committee provides appropriate and timely feedback to the HCGs relating to all information regarding the HCG and its providers.
4. Each Committee shall review and forward to the MEC a synopsis of any subcommittee and/or workgroup findings.
5. The Medical Executive Council shall be the approving body of all reporting committees. Approval of the minutes by the Chief of Staff and the HS Director indicates that all conclusions and actions recommended are approved in final format, including creation and discontinuation of boards, councils, and committees

Section 5.05 Establishment of Committees

1. The MEC may, by resolution and upon approval of the Director, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions.
2. The MEC may, by resolution and upon approval of the Director, dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

ARTICLE VI. MEDICAL STAFF MEETINGS

1. Regular Meetings: Regular meetings of the General Medical Staff shall be held at least three (3) times per year. A record of attendance shall be kept.
2. Special Meetings: Special meetings of the General Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the MEC. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Director in writing and stating the reason(s) for the request.

3. Quorum: For purposes of Medical Staff business, 25-33% of the total membership of the medical staff membership entitled to vote constitutes a quorum.

4. Meeting Attendance: Members of the Organized Medical Staff are encouraged to attend 25% of regular Medical Staff meetings and 50% of HCG-level meetings. Medical Staff members, or their designated Medical Staff alternates, shall be encouraged to attend a minimum of 50% of council and committee meetings in which they are members, unless specifically excused by the council or committee chairperson for appropriate reasons. To help ensure the flow of information, an alternate may vote in lieu of the member represented.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING *

Section 7.01 General Provisions

1. Independent Entity: VALBHS is an independent entity, granting privileges to the medical staff through the MEC and Governing Body as defined in these Bylaws and in accordance with VHA Handbook 1100.19. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Mid-Level Practitioner, and Associated Health Practitioner reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff and Mid-Level and Associated Health Practitioners must practice under their privileges or scope of practice.

2. Credentials Review: All Licensed Independent Practitioners (LIP), and all Mid-Level and Associated Health Practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. All Mid-Level and Associated health Practitioners will be subjected to full credentials review at the time of initial appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a maximum period of 2 years.

3. Deployment/Activation Status:

   a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be placed in a “Deployment/Activation Status” and the credentialing file will remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of l994 (USERRA), the Practitioner will update the credentialing file to current status.

   b. After verification of the updated information is documented, the information will be referred to the Practitioner’s Service Chief then forwarded to the MEC for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.

c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.

d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care.

4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:

a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.

b. Federal law authorizing VA to contract for health care services.

5. Initial Focused Professional Practice Evaluation:

a. The initial focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This occurs with a new Practitioner or an existing Practitioner who request a new privilege. The performance monitoring process is defined by each Service and must include;

i) Criteria for conducting performance monitoring

ii) Method for establishing a monitoring plan specific to the requested privilege

iii) Method for determining the duration of the performance monitoring

iv) Circumstances under which monitoring by an external source is required.

b. An initial Medical Staff appointment does not equate to HR employment. FPPE does not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below;

i) Initial and certain other appointments made under 38 U.S.C. 7401(l), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations.

ii) If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply the same processes to the evaluation of individuals employed under provision of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.

6. Ongoing Professional Practice Evaluation:

a. The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the medical staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for medical staff leadership. Each service chief should consider what hospital, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.

i.) The timeframe for ongoing monitoring is to be defined locally. It is suggested that, at a minimum, service chiefs must be able to demonstrate that relevant practitioner data is reviewed on regular bases (i.e. more than once a year). Consideration may be based on a period of time or a specified number of procedures, and may consider high risk or high volume for an adjustment to the frequency.

ii.) With very few exceptions, VHA data standing alone is not protected by 38 U.S.C. 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. Data that is not previously identified as protected by 38 U.S.C. 5705 and is collected as provider-specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program, and compared to pre-defined facility triggers or de-identified quality management data.

iii.) In those instances where a practitioner does not meet established criteria, the service chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.

iv.) The Executive Committee of the Medical Staff must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.

v.) The Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

Section 7.02 Application Procedures *

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines. <***NOTE***: *See VHA Handbook 1100.19 for full process .>* The applicant is bound to be forthcoming, honest and truthful. To be complete, applications for appointment must be submitted by the applicant on forms approved by the VHA, entered into the internet-based VHA VetPro credentialing database, and include authorization for release of information pertinent to the applicant and information listed below. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the Practitioner says the information provided is factually incorrect. <***NOTE***: *Medical Staff appointment does not equate to HR employment.>*

   a. Items specified in Article III, Section 2, Qualifications for Medical Staff Membership, including:

      i) Active, Current, Full, and Unrestricted License: <***Note:*** *In instances where Practitioners have multiple licenses inquiry must be made for all licenses and the process as noted in VHA Handbook 1100.19 must be followed for each license (38USC 7402). Limitations defined by state licensing authorities must also be considered when considering whether licensure requirements are met.>*

      ii) Education.

      iii) Relevant training and/or experience.

      iv) Current professional competence and conduct.

      v) Physical and Mental health status.

      vi) English language proficiency.

      vii) Professional liability insurance (contractors only).

      viii) BLS approved program using criteria by the American Heart Association. Clinically active staff nominally includes all physicians and nurses. ACLS provider certification is required for staff identified in Healthcare System Policy No. 11-13, “Cardiopulmonary Resuscitation (CPR)”

      ix) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and will acknowledge that they have received a copy of “The Sedation and Analgesia by Non-Anesthesia Providers” policy and agree to the guidelines outlined in the policy.

b. U.S. Citizenship: Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, Practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment with proof of current visa status and Immigration and Naturalization Service documentation regarding employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.

c. References: The names and addresses of a minimum of four individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer or for individuals completing a residency; one reference must come from the residency training program director. The Director may require additional information.

d. Previous Employment: A list of all health care institutions or other organizations where the Practitioner is/has been appointed, utilized or employed (held a professional appointment), including:

   i) Name of health care institution or practice.

   ii) Term of appointment or employment and reason for departure.

   iii) Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary surrender.

e. DEA/CDS Registration: A description of:

   i) Status, either current or inactive.

   ii) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, the Practitioner's DEA/CDS registration.

f. Sanctions or Limitations: Any sanction or penalty by any licensing authority, including current pending challenges, whether a license or registration ever held to practice a health occupation by the Practitioner has been suspended, revoked, voluntarily surrendered, or not renewed.

g. Liability Claims History: Status (Open, Pending, Closed, Dismissed, etc.) of any claims made against the Practitioner in the practice of any health occupation including final judgments or settlements, if available.

h. Loss of Privileges: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

i. Release of Information: Authorization for release of information, including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.

j. Pending Challenges: Pending challenges against the Practitioner by any hospital, licensing agency, professional group, or society.

2. Primary Source Verification: In accordance with VHA Handbook 1100.19 Credentialing and Privileging and VA Handbook 5005, Part II, Chapter 3 the facility will obtain primary source verification of:

   a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article VIII, Section 8.02.

   b. Verification of current or most recent clinical privileges held, if available.

   c. Verification of status of all licenses current and previously held by the applicant.

   d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.

   e. Evidence and verification of board certification or eligibility, if applicable.

   f. Verification of education credentials used to qualify for appointment including all postgraduate training.

   g. Evidence of registration with the National Practitioner Data Bank (NPDB) Proactive Disclosure Service and the Healthcare Integrity and Protection Data Bank, for all members of the Medical Staff and those Practitioners with clinical privileges.

   h. For all physicians screening will be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner.

   i. Confirmation of health status on file as documented by a physician approved by the Organized Medical Staff.

   j. Evidence and verification of the status of any alleged or confirmed malpractice.

   k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made.

3. The applicant's attestation to the accuracy and completeness of the information submitted.

4. Burden of Proof: The applicant has the burden of obtaining and producing all needed information for a proper evaluation of the applicant's professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of the request to the applicant may serve as a basis for denial of employment consideration.

5. VetPro Required: All healthcare providers must submit credentialing information into VetPro as required by VHA policy.

Section 7.03 Process and Terms of Appointment *

1. HCG Chief Recommendation: The HCG Chief or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met.
2. CMO Review: In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be referred to the VISN Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the MEC if the response from the NPDB-HIPDB query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of $550,000 or more, or (c) two medical malpractice payments totaling $1,000,000 or more. The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Chief's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.
3. MEC Recommendation: The Credentialing & Privileging Committee, on behalf of the MEC, recommends to the HS Director appointment to the Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
4. Director Action: Recommended appointments to the Medical Staff should be acted upon by the Director within 30 work days of receipt of a fully complete application, including all required verifications, references and recommendations from the appropriate Service Chief and MEC.
5. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or return of the application because of inadequate information.

Section 7.04 Credentials Evaluation and Maintenance *

1. Evaluation of Competence: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the Practitioner applying for clinical privileges has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.
2. Good Faith Effort to Verify Credentials: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined

as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The entry will describe the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. It will also indicate when a secondary source, e.g. copy of diploma, confirmation from someone in practice or training at the same time, is being used in lieu of primary-source verification. The applicant should assist in providing required information for this documentation. <***Note:*** *Verification of licensure is excluded from good faith effort in lieu of verification*>

3. Maintenance of Files: A complete and current Credentialing and Privileging (C&P) file including the electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C&P file is the responsibility of the Chief of Staff. Any time a file is found to lack required documentation, without an entry as noted above in paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain the documentation.

4. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a "for-cause" event requiring a focused review.

   a. A FPPE, implemented at time of initial appointment, will be based on the Practitioner's previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, chart reviews, etc. and should be discussed with the Practitioner by the Service Chief.

   b. A FPPE at the time of request for additional privileges will be for a period of time, a number of procedures, and/or chart review to be set by the Service Chief.

   c. A FPPE initiated by a "for-cause" event will be set by the Service Chief. FPPE for cause ,where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges i.e., summary suspension

   d. The FPPE monitoring process will clearly define and include the following:

      i) Criteria for conducting the FPPE.

      ii) Method for monitoring for specifics of requested privilege.

      iii) Statement of the "triggers" for which a "for-cause" FPPE is required.

      iv) Measures necessary to resolve performance issues which will be consistently implemented.

   e. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the Service's policies and procedures.

f. If at any time the Service Chief or designee cannot determine the competence of the Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:

i) Extension of FPPE review period

ii) Modification of FPPE criteria

iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner)

iv) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported)

Section 7.05 Local/VISN-Level Compensation Panels

Local or VISN-level Compensation Panels recommend the appropriate pay table, tier level and market pay amount for individual medical staff members, as outlined in VA Handbook 5007, Part IX/21. Appointment actions recommended by the Professional Standards Board require a separate review for a pay recommendation by the appropriate Compensation Panel.

ARTICLE VIII CLINICAL PRIVILEGES *

Section 8.01 General Provisions

1. Clinical privileges are granted for a period of no more than 2 years.
2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.

   a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner’s performance.

   b. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.

   c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate’s application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the MEC. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7). *<**NOTE**: This paragraph should not be changed without verifying that changes are consistent with applicable policy, regulations, and accreditation standards.>*

3. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Service Chief
4. Associated Health and Mid-Level Practitioners who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.
5. Requirements and processes for requesting and granting privileges are the same for all Practitioners who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
6. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all Service Chiefs must recommend the practice.
7. Exercise of clinical privileges within any Service is subject to the rules of that Service and to the authority of that Service Chief.
8. When certain clinical privileges are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.
9. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.
10. Teleconsultation: All Practitioners providing teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

Section 8.02 Process and Requirements for Requesting Clinical Privileges *

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.
2. Requests in Writing: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.
3. Credentialing Application: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:

a. Complete appointment information as outlined in Section 2 of Article VI.

b. Application for clinical privileges as outlined in this Article.

c. Evidence of professional training and experience in support of privileges requested.

d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEC.

e. A statement of the current status of all licenses and certifications held.

f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.

h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

i. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association is required of all clinically active staff. For new appointments this will be done prior to or within 90 days of employment

4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.

5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that he/she has received a copy of Sedation and Analgesia by Non-Anesthesia Providers policy and agree to the guidelines outlined in the policy.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges *

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:

a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur

over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.

b. Supporting documentation of professional training and/or experience not previously submitted.

c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEC.

d. Documentation of continuing medical education related to area and scope of clinical privileges, (consistent with minimum state licensure requirements) not previously submitted.

e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.

f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

g. Names and addresses of two peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

h. Names of other hospitals or facility at which privileges are held and requests for copies of current privileges held.

2. Verification: Before granting subsequent clinical privileges, the Medical Staff Office will ensure that the following information is on file and verified with primary sources, as applicable:

a. Current and previously held licenses in all states.

b. Current and previously held DEA/State CDS registration.

c. NPDB-HIPDB PDS Registration.

d. FSMB query

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

g. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and FPPE.

h. Continuous education to meet any local requirements for privileges requested.

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges *

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Chief. This request will initiate the recredentialing process as noted in the VHA Handbook 1100.19.
2. Primary source verification is conducted if applicable, e.g. provider attests to additional training.
3. Current NPDB-HIPDB PDS Registration prior to rendering a decision.
4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the MEC followed by the Director's/Governing Body's approval.

Section 8.05 Recommendations and Approval for Initial/Renewal, Modification/Revision of Clinical Privileges *

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.
2. The Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.
   a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:
      i) Medical/Clinical knowledge
      ii) Interpersonal and Communication skills
      iii) Professionalism
      iv) Patient Care
      v) Practice-based Learning & Improvement
      vi) System-based Practice
   b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring

and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE.

3. MEC recommends granting clinical privileges to the Facility Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. The Credentialing & Privileging Committee, a subcommittee of MEC has been delegated responsibility for the initial review and recommendation; however, this information must be reviewed and approved by the MEC.
4. Clinical privileges are acted upon by the Director within 30 calendar days of receipt of the MEC recommendation to appoint. The Director's action must be verified with an original signature.
5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A Copy of approved privileges is given to the Practitioner and is readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.
6. Approval of the scope of practice and prescriptive authority for Mid-Level and Associate Health Practitioners is facilitated through the Medical Staff Process.

Section 8.06 Exceptions*

1. **Temporary Privileges for Urgent Patient Care Needs:** Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of an initial appointment for a limited period of time (not to exceed 45 calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff.

a. Temporary privileges are based on verification of the following:

   i) One, active, current, unrestricted license with no previous or pending actions.

   ii) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.

   iii) Current comparable clinical privileges at another institution.

   iv) Response from NPDB-HIPDB PDS registration with no match.

   v) Response from FSMB with no reports.

   vi) No current or previously successful challenges to licensure.

   vii) No history of involuntary termination of medical staff membership at another organization.

   viii) No voluntary limitation, reduction, denial, or loss of clinical privileges.

   ix) No final judgment adverse to the applicant in a professional liability action.

b. A completed application must be submitted within three calendar days of temporary privileges being granted and credentialing completed.

2. **Emergency Care:** Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.

a. **Disaster Privileges**: As described in the Facility's Emergency Management Plan and Healthcare System Policy No: 00-09, "Credentialing and Privileging, and Scope of Practice Review of Licensed Independent Practitioners and Mid-level Practitioners":

   i) In circumstances of disaster(s) in which the Disaster Plan has been activated, the Director or the Chief of Staff or designee(s) may grant emergency privileges. VetPro will be used when possible. A government-issued photo identification card, current hospital photo identification card, and evidence of current license to practice are required. An attempt will be made to verify license information, verify current hospital affiliation(s), and query the National Practitioner Data Bank. If possible, the Health Care Group Chief will determine the type of privileges permitted. Emergency privileges may be granted by the Director or Chief of Staff or designee(s).

b. Granting of emergency privileges will include review by the Emergency Privileging Coordinator (employee of the Medical Staff Office unless otherwise designated by the Chief of Staff/Medical Director or Director) of:

   i) Current Government-issued photo identification (e.g. driver's license or passport) **and at least one of the following:**

      (1) Current hospital photo identification and evidence of license to practice; or

      (2) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);or

      (3) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a Federal, State, or municipal entity.

   ii) And as soon as the situation is under control or within 72 hours:

      (1) A list of current hospital affiliations where the individual holds current privileges,

      (2) A National Practitioner Data Bank Inquiry, if communication is possible, **and**

      (3) Verification of the volunteer practitioner's identity by a current hospital or medical staff member.

c. Practitioners who are authorized by a local, state, or Federal agency to respond during a disaster may be utilized

d. The practitioner will be paired with a currently credentialed Medical Staff member and should act only under his/her direct supervision.

e. Disaster privileges will be evaluated within 72 hours by the granting authority to determine if the provider should continue to have assigned privileges. After evaluation the disaster privileges can be granted for ten days or for the duration of the disaster or emergency situation, whichever is shorter, or until communication is established, and the practitioner can be converted to a Temporary Appointment for urgent patient care needs

f. Upon termination of the disaster, the practitioner will submit a complete application and full credentialing will be accomplished within 120 days in order to determine if any follow-up is required.

g. During a disaster, a physician, dentist, or other licensed practitioner may present himself/herself to the HS. Staff, particularly nurses, clerks, doctors, and Human Resource (HR) employees should be alerted to direct such professional to the person designated as the Emergency Privileging Coordinator. The hospital representative will record the date, time and request for emergency privileges. To the extent possible, HCG Chiefs will be consulted as to the type of privileges the individual should be permitted. The HS Emergency Privileging Coordinator will make every effort to immediately contact (1) the facility, clinic, or group identified to verify practice and standing and (2) the State Professional Licensing board to verify license and standing and the HIPDB. Once privileges are granted, the volunteer provider will be issued a colored wristband to identify them as a volunteer licensed independent practitioner granted disaster privileges.

h. A practitioner's privileges or scope of practice will be rescinded immediately by the Chief of Staff/Director or his/her designee in the event any information or observation suggests the person is not capable of rendering necessary emergency services. There will be no rights to a hearing or review regardless of the reason for termination.

3. **Inactivation of Privileges**: The inactivation of privileges occurs when a Practitioner is not an actively practicing member of the medical staff for an extended period of time such as extended sick leave or sabbatical with or without clinical practice while on sabbatical.

a. When the Practitioner returns to the Facility, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be verified again. Inactivation of privileges may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.

b. At the time of inactivation of privileges, including separation from the medical staff, the Director ensures that within 7 calendar days of the date of separation, information is received suggesting that the Practitioner met generally accepted standards of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.

4. **Deployment and Activation Privilege Status**: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the

privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment. <***NOTE**: No step in this process should be a barrier in preventing the Practitioner from returning to the Facility in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994*.>

a. Facility staff request that a Practitioner returning from active duty communicate with the Facility staff as soon as possible upon returning to the area.

b. After the electronic credentials file has been reopened for credentialing, the Practitioner must update the licensure information, health status, and professional activities while on active duty.

c. The credentials file must be brought to a verified status. If the Practitioner performed clinical work while on active duty, an attempt is made to confirm the type of duties, the Practitioner's physical and mental ability to perform these duties, and the quality of the work. This information must be documented.

d. The verified credentials, the Practitioner's request for returning the privileges to an Active Status, and the Service Chief's recommendation are presented to the MEC for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the MEC is documented and forwarded to the Director for recommendation and approval of restoring the Practitioner's privileges to Current and Active Status from Deployment and/or Activation Status.

e. In those instances when the Practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.

f. In those instances where the privileges lapsed during the call to active duty, the Practitioner needs to provide additional references for verification and Facility staff need to perform all verifications required for reappointment.

g. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief, must consider whether a request for modification of the privileges held prior to the call to active duty should be initiated on a short-term basis.

h. If the file cannot be brought to a verified status and the Practitioner's privileges restored by the Director, the Practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VetPro:

    i) Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.

    ii) Registration with the NPDB-HIPDB PDS with no match.

    iii) A response from the FSMB with no match.

iv) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.

v) Documentation of the Temporary Appointment on the Appointment Screen 9

Section 8.07 Medical Assessment

A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, a maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA and hospital policy. The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.

ARTICLE IX INVESTIGATION AND ACTION *

1. Request for Investigation: Whenever the behaviors, activities and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct, which constitute the grounds for the request. The Chief of Staff promptly notifies the Director in writing of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process.

2. Fact Finding Process: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article IX, a fact finding process will be implemented. This fact-finding process should be completed within 30 days or there needs to be documentation as to why that was not possible. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities and/or professional conduct the Practitioner

are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the Credentialing & Privileging Committee/ Professional Standards Board.

3. Review by the Credentialing & Privileging Committee/ Professional Standards Board: The Credentialing & Privileging Committee/ Professional Standards Board investigates the charges and makes a report of the investigation to the MEC within 14 days after the having been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the Credentialing & Privileging Committee/ Professional Standards Board to discuss, explain or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation by the Credentialing & Privileging Committee/ Professional Standards Board is an administrative matter and not an adversarial Hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations reported to the MEC.

4. MEC Action: Within 14 days after receipt of a report from the Credentialing & Privileging Committee/ Professional Standards Board the MEC acts upon the request. If the action being considered by the MEC involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the MEC prior to the committee's action on such request. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. A record of such proceeding is made by the MEC.

   a. The MEC may reject or modify the recommendations; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommend that the Practitioner's staff membership be suspended or revoked.

   b. Any recommendation by the MEC for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

   c. Reduction of privileges may include, but not be limited to, functioning under supervision[1], restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as

[1] See the definition of Proctoring for an explanation of the difference between proctoring and supervision.

demonstration of recovery from a medically disabling condition or further training in a particular area.

d. Revocation of privileges refers to the permanent loss of clinical privileges.

5. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, or portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by Facility Director.

   a. The Chief of Staff convenes the PSB to investigate the matter, meet with the Practitioner if requested and make a report thereof to the MEC within fourteen (14) days after the effective date of the Summary Suspension.

   b. Immediately upon the imposition of a Summary Suspension, the Service Chief or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.

6. Automatic Suspension of Privileges: An Automatic Suspension occurs immediately, upon the occurrence of specific events.

   a. The medical staff membership and clinical privileges of any Practitioner with delineated clinical privileges shall be automatically suspended if any of the following occurs:

      i) The Practitioner is being investigated, indicted or convicted of a misdemeanor or felony that could impact the quality and safety of patients.

      ii) Failure on the part of any staff member to complete medical records in accordance with system policy will result in progressive disciplinary action to possible indefinite suspension.

      iii) The Practitioner is being investigated for fraudulent use of the Government credit card.

      iv) Failure to maintain the mandatory requirements for membership to the medical staff. (e.g., whenever a license (or equivalent legal credential) of a Medical Staff member is revoked or restricted, or if the individual fails to renew his/her license prior to expiration. No right to a hearing or appellate review exists under these conditions.

      v) The Practitioner is being investigated for conduct/behavior issues not impacting patient care.

   b. The Chief of Staff convenes the Credentialing & Privileging Committee/Professional Standards Board to investigate the matter and make a report thereof to the MEC within fourteen (14) days after the effective date of the Automatic Suspension.

   c. Immediately upon the occurrence of an Automatic Suspension, the HCG Chief or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.

d. If there are more than three automatic suspensions of privileges in one calendar year, or more than 20 days of automatic suspension in one calendar year, a thorough assessment of the need for the Practitioner's services must be performed and documented and appropriate action taken.

7. Actions Not Constituting Corrective Action: The MEC will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:

   a. The appointment of an ad hoc investigation committee;

   b. The conduct of an investigation into any matter;

   c. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview or conference before the Credentials Committee, any ad hoc investigating committee, the Chief of Staff, or any other committee or sub-committee with appropriate jurisdiction in connection with any investigation prior to a proposed adverse recommendation or action;

   d. The failure to obtain or maintain any other mandatory requirement for Medical Staff membership;

   e. The imposition of proctoring or observation on a Medical Staff member which does not restrict clinical privileges or the delivery of professional services to patients;

   f. The issuance of a letter of warning, admonition, or reprimand;

   g. Corrective counseling;

   h. A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education; or

   i. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.

ARTICLE X FAIR HEARING AND APPELLATE REVIEW *

1. Reduction of Privileges: <***NOTE***: *All time frames in this section are required by 1100.19*>

- Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

  i) A description of the reason(s) for the change.

  ii) A statement of the Practitioner‘s right to be represented by counsel or a representative of the individual’s choice, throughout the proceedings.

- The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the

Practitioner may respond in writing to the Chief of Staff's written notice of intent. The Practitioner must submit a response within l0 workdays of the Chief of Staff's written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed l0 additional workdays except in extraordinary circumstances.

- Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the Practitioner disagrees with the Director's decision, a hearing may be requested. The Practitioner must submit the request for a hearing within five (5) workdays after receipt of decision of the Director.

2. Convening a Panel: The facility Director must appoint a review panel of three unbiased professionals, within 5 workdays after receipt of the Practitioner's request for hearing. These three professions will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

   a. The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.

   b. During such hearing, the Practitioner has the right to:

      i. Be present throughout the evidentiary proceedings.

      ii. Be represented by an attorney or other representative of the Practitioner's choice. ***NOTE:*** *If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses.*

      iii. Cross-examine witnesses.

   NOTE: *The Practitioner has the right to purchase a copy of the transcript or tape of the hearing.*

3. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.

4. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.

a. The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

b. The facility Director must issue a written decision within 10 workdays of the date of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.

c. If the Practitioner wishes to appeal the Director's decision, the Practitioner may appeal to the appropriate VISN Director within 5 workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

d. The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the Practitioner's appeal.

NOTE: *The decision of the VISN Director is not subject to further appeal.*

The hearing panel chair shall do the following:

- Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

- Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.

- Maintain decorum throughout the hearing.
- Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
- Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.
- Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.
- Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

Practitioner Rights:

- The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

- The panel will complete its review and submit its report within 15 workdays of the date of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.
- The Director will issue a written decision within l0 workdays of the day of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.
- The Practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.
- The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the Practitioner's appeal. The decision of the VISN Director is not subject to further appeal.
- A Practitioner who does not request a review panel hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN Director within five workdays after receipt of the Director's decision.
- The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.
- If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, if greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

5. Revocation of Privileges:

- Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures.

  i) In instances where revocation of privileges is proposed for permanent employees, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations.

  ii) For probationary employees appointed under 38 U.S.C. 7401(1) and 38 U.S.C. 7405, the proposed revocation will be combined with probationary separation procedures, which constitutes an automatic revocation as contained in VA Handbook 5021 Employee/Management Relations.

- Revocation procedures will be conducted in a timely fashion. If discharge, separation during probation, or termination of appointment is not proposed, revocation of clinical privileges may not occur. Even though a revocation of privileges requires removal from both employment and appointment to the medical staff, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. For example a surgeon's privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by MEC for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

6. Reporting to the National Practitioner Data Bank[2]:

- Tort ("malpractice") claims are filed against the United States government, not individual Practitioners. There is no direct financial liability for named or involved Practitioners. Government attorneys (Regional Counsel, General Counsel, U.S. Attorney) investigate the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.
- When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioners should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.
- Practitioners are also identified and notified at the time a tort claim is filed so that they may assist regional and general counsel in defending the case and in decisions concerning denial or settlement.
- Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff's case when a tort claim settlement is submitted for review.
- VA only reports adverse privileging actions that adversely affect the clinical privileges of Physician and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4 The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be reported to the

[2] Reference VHA Handbook 1100.17.

NPDB. After the final action, the reduction or revocation as well as the summary suspension if greater than 30 days will be reported.

7. Reporting to State Licensing Boards: VA has a responsibility to report to state licensing boards appointed or suspended members of the Medical Staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

8. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

ARTICLE XI RULES AND REGULATIONS *

1. As may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to identify the level of clinical practice that is required of each member of the Medical Staff and of all others with delineated clinical privileges or practicing under a Scope of Practice, Medical Staff Rules and Regulations may be adopted. Rules and Regulations may be adopted, amended, repealed or added by a majority vote of the members (as determined by the Facility) of the MEC present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. Medical Staff Rules and Regulations must be approved by the Director.

ARTICLE XII AMENDMENTS *

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff or directly to the governing body. Recommendations for change come directly from MEC. Changes to the bylaws are amended, adopted and voted on by the Organized Medical Staff as a whole and then approved by the Director. The Bylaws are amended and adopted by a majority endorsement of the active medical staff.

2. The MEC may provisionally adopt and the Director may provisionally approve urgent amendments to the Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the medical staff. After adoption, these urgent amendments to the

Rules and Regulations will be immediately communicated back to the Organized Medical Staff for retrospective review and comment on the provisional amendment. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.04 should be followed.

3. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
4. All changes to the Bylaws require action by both the Organized Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.
5. Changes are effective when approved by the Director.

ARTICLE XIII ADOPTION *

These Bylaws shall be adopted upon recommendation of the Organized Medical Staff at any regular or special meeting of the Organized Medical Staff at which a quorum is present. They shall replace any previous Bylaws and shall become effective when approved by the Director.

If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy or an amendment thereto, they must first communicate the proposal to the MEC. If the MEC proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the medical staff. When the MEC adopts a policy or amendment thereto, it must communicate this to the medical staff.

Adoption, amendment or associated details that reside in medical staff bylaws cannot be delegated.

RECOMMENDED

/s/ Norman Ge, MD — 1/14/14

Norman N. Ge, MD, FACS — Date

Interim Chief of Staff

APPROVED

/s/ Anthony DeFrancesco — 1/15/14

Isabel Duff, MS — Date

Director

MEDICAL STAFF RULES

1. GENERAL

A. The Rules relate to role and/or responsibility of members of the Medical Staff and individuals with clinical privileges in the care of any and all patients.

B. Rules of Departments or Services will not conflict with each other, rules and policies of the Medical Staff, or with requirements of the Governing Body.

C. The Medical Staff as a whole shall hold meetings at least annually.

D. The MEC serves as the executive committee of the Medical Staff and between the annual meetings, acts in their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.

E. Each of the clinical Services shall conduct meetings at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by medical staff and responsible party of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.

F. Information used in quality improvement as referenced in Article IX, cannot be used when making adverse privileging decisions.

2. PATIENT RIGHTS *

A. Patient's Rights and Responsibilities: This Organization supports the rights of each patient and publishes policy and procedures to address rights including each of the following:

i) Reasonable response to requests and need for service within capacity, mission, laws and regulations.

ii) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.

iii) Collaboration with the physician in matters regarding personal health care.

iv) Pain management including assessment, treatment and education.

v) Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.

vi) Formulation of advance directives and appointment of surrogate to make health care decisions (38 CFR17.32).

vii) Access to information necessary to make care decisions that reflect patient's wishes, including potential outcomes, risks and benefits and consequences of refusal of treatment. Access to such information will be in such a way that the patient receives the information in a manner he/she understands.

viii) Access to information about patient rights, handling of patient complaints.

ix) Participation of patient or patient's representative in consideration of ethical decisions regarding care.

x) Access to information regarding any human experimentation or research/education projects affecting patient care.

xi) Personal privacy and confidentiality of information.

xii) Action by a legally authorized person to exercise a patient's rights if a patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or unable to communicate his/her wishes.

xiii) Authority of Chief of Staff or Health Care Group Chief to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available).

xiv) Foregoing or withdrawing life-sustaining treatment including resuscitation.

xv) Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.

B. Living Will, Advance Directives, and Informed Consent (38 CFR 17.32)

i) Competent patients have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.

ii) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with, as appropriate, other members of the treatment team (38 USC sections 7331).

iii) With respect to the documentation of decision making concerning life-sustaining treatment, the following information, at a minimum, will be documented in the progress notes by the attending physician: The patient's diagnosis and prognosis; an assessment of the patient's decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.

iv) Competent patients will be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning life-

sustaining treatment will be honored, and will be documented in the medical record.

v) Advance Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any competent patient may execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a declarant at any time.

vi) Substituted Judgments: The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:

(a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.

(b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.

(c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the attending physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's

own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body, or Chief of Staff.

3. RESPONSIBILITY FOR CARE*

A. Conduct of Care

i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff.

(a) There must be an appropriately credentialed and privileged staff practitioner or board certifiable practitioner available in the facility at all times

(b) An On-Call schedule will be maintained so that all patients have an appropriate physician or practitioner immediately available to attend them for any emergency that may occur.

(c) Food and nutrition products are administered only on the prescription or order of a Medical Staff member, an authorized house staff member, or other individual who has been granted authority to write such prescriptions or orders, within their scope of practice.

(d) Progress note entries should be identified as to the type of entry being made, (e.g., Resident Note, Attending Note, Off Service Note, etc.). The Attending Note must be signed by the Attending physician.

(e) Progress notes will be written by the Practitioner at least once daily on all acutely ill patients with the exception of Spinal Cord Injury or Blind Rehabilitation patients. Progress notes are written for all patients seen for ambulatory care by the medical staff.

(f) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written or, at minimum, countersigned by the attending physician in the patient's medical record. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient’s rights will be observed. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the Facility staff, particularly the nursing staff, so that all involved professionals understand the order and its implications. (*DNR – VHA Handbook 1004.3)*

(g) Patients will not be transferred out when the Facility has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer only after authorization is given by the

appropriate provider as defined in facility policy. (*Inter-Facility Transfer Policy - VHA Directive 2007-015)*

(h) Communication with the patient to allow full participation in their care, treatment or services received shall be complete, accurate, timely, unambiguous, and understood by the patient.

ii) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and across Departments and Services and between all staff members who have clinical privileges.

iii) There is to be a comparable level of quality of surgical and anesthesia care throughout the Facility.

B. Emergency Services

i) Specific designation of physicians will be made for the emergency function. The Admitting/Emergency Department assignment is defined part of this HS and is approved by VHA Headquarters.

ii) All applicants 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 referrals

C. Admissions

i) Preadmission Screening-All potential admissions to an acute bed service will be screened prior to admission according to HSP 04-09 “Utilization Management”

ii) Based on the medical needs of the patient, he/she may be admitted by any physician or dentist member of the Medical Staff who was granted specific admitting privileges.

(a) In general, patients admitted to the HS shall be assigned to the HCG most directly concerned the treatment of the disease for which hospitalization was required; a lack of available beds in a particular HCG, however, will not preclude temporary admission to another area of the hospital, if immediate care is required.

(b) Physicians admitting patients from the Emergency Department must make a provisional diagnosis before admission to ensure that no patient shall record. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

(c) The history and physical examination (H&P) of a patient presenting with an emergent health problem shall be focused but include at least:

(1) A brief statement of the medical/surgical problem.

(2) Vital signs

(3) Physical examination of organs/systems most likely to be involved in the presenting health problem including examination of the heart and lungs.

(4) Oral and Maxillofacial Surgery-When a patient is admitted for oral and maxillofacial surgical care, the admitting dentist has the primary responsibility for the patient. In case of injuries to other body systems, medical illnesses noted at the time of admission, or medical problems developing during hospitalization, an appropriate physician member of the staff will be consulted and will assume responsibility for those injuries or medical problems. Qualified dentists are authorized to perform history-taking and physical examination of those patients under their care not exhibiting medical problems requiring physician care, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s) and to record their findings in the medical record with timely completion thereof. As a member of the Medical Staff (and in accordance with his/her individual clinical privileges), a dentist is responsible for arranging admission of the patient, writing admission notes and orders, performing initial workup, obtaining consultations as indicated, providing appropriate treatment of the patient, completing all medical records, and assuring appropriate after-care.

(5) The H&P is one component of the integrated interdisciplinary admission assessment.

(i) A physician member or the Medical Staff or other privileged health provider will complete the H&P within 24 hours of admission to an acute or subacute bed. When a resident house staff (house officer), medical student, nurse practitioner, or physician assistant completed the H&P, the attending shall review, concur, and co-sign the H&P within 24 hours. The Community Living Center (CLC) H&P must be completed within 24 hours before the scheduled admission or 72 hours after admission.

i. If the patient is a readmit to an acute or subacute bed within 30 days of the date of the previous H&P, a legible copy of the H&P can be used for the current admission. An interim progress note must be made identifying any changes that have taken place.

ii. If the patient is a readmit to either a subacute or long term care bed, the H&P must be completed within 72 hours after admission unless an H&P was previously done during this time frame, an interim progress note

indicating any changes that have occurred will be entered.

(ii) The basic elements of an acceptable H&P are included in the CPRS online templates. Any additional notes and cosignature should be added to the H&P templates as an electronic addendum or as an appropriately titled note.

(iii) When all required admission assessments are complete, the findings will be reviewed in an interdisciplinary format, as defined by in the individual units, and an interdisciplinary prioritized plan of care established. The physician and dentist will be an active team member.

(iv) The work-up of patients admitted for psychiatric care will, in addition to the other requirement have an interdisciplinary psychosocial assessment performed within three days. The combined medical data and psychosocial data will be the foundation upon which the comprehensive and individual patient treatment plan will evolve. Interim treatment plans should be used during the time necessary for completion of the full interdisciplinary data base. The admission work-up by the initial physician or practitioner will be the basis of the interim plan. The basic elements of an acceptable psychosocial assessment are:

History of:

- Familial relationships-childhood history
- Educational background
- Vocational history
- Cultural background
- Military service history
- Socioeconomic status and current living situation
- Substance Abuse (alcohol or drugs)-co-occurrence and previous treatment
- Maladaptive or problem behaviors
- Psychological assessment
- Current emotional state
- Behavioral functioning
- Emotional functioning
- Mental functioning

(v) Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry

(vi) Podiatrists are responsible for the part of the examination relating to podiatry

(6) Responsibilities-Each patient is assigned to the care of a member of the Medical Staff who if responsible for :

(i) Total medical care of the patient

(ii) Prompt completion and accuracy of the medical record

(iii) Transmitting reports on patient's condition to the referring practitioner and/or family.

(iv) Acting in the capacity of supervisor of house officers or of other non-medical staff professional personnel as described in Section 5 of these Rules and Regulations and assuring that those designated to care for the patient are doing so in an adequate and timely manner; he/she will document such supervision in the medical record of each patient under his/her control. The HCG (or section) Chief bears responsibility to ensure compliance.

D. Assuring that in the case of surgery, the H&P, a diagnosis and appropriate test results are recorded before the time stated for the operation

E. Consultations:

i) Consultation: Except in an emergency, consultation with a qualified physician is desirable when in the judgment of the patient's physician:

(a) The patient is not a good risk for operation or treatment,

(b) The diagnosis is obscure, and/or

(c) There is doubt as to the best therapeutic measures to be utilized.

ii) Consultant: A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff and the Professional Standards Boards on the basis of an individual's training, experience, and competence.

iii) Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A 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.

iv) Responsibility for Requesting Consultations: The patient's physician, through the Chiefs of Services, shall make certain that members of the staff do not fail in the matter of providing consultation as needed.

v) Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.

F. Discharge Planning: Discharge planning is initiated as early as a determination of need is made.

i) Discharge planning provides for continuity of care to meet identified needs.

ii) Discharge planning is documented in the medical record.

iii) Criteria for discharge are determined by the Multidisciplinary Treatment Team.

iv) Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.

G. Discharge

i) Patients shall be discharged from the Facility only upon the written order of the physician and the discharge summary will be dictated no later than the day of discharge. At time of dictating the final summary, the responsible member of the Medical Staff shall review the medical record to ensure that documents therein pertain to the patient and contain accurate data. The record shall be completed within fourteen (14) days of the discharge of the patient. The physician or dentist shall complete his/her portion of the record within fourteen (14) days, including authentication.

ii) Patients from Ambulatory Surgery/Procedure Unit can be discharged based upon order of Licensed Independent Practitioner familiar with the patient or when the Practitioner is not available, based on relevant medical staff approved criteria. The Practitioner's name is recorded in the patient's medical record.

H. Autopsy (*VHA Handbook 1106.01)*

i) Autopsy services are provided by the Pathology & Laboratory Medicine Service. The availability of these services will be made known to the family of each decedent and the Attending Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within the Facility.

ii) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-155. Whenever possible, the physician responsible for the care of the patient at the time of death will be designated to request permission from the next of kin to perform an autopsy.

iii) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.155 and Healthcare System Policy No. 113-01, Signing of Death certificates and Release of Remains and Autopsy Procedures" (which includes criteria for assignment to medico-legal status).

iv) Autopsy Rates. Autopsies are encouraged as per VHA policy.

v) Autopsy Criteria. VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in Healthcare System Policy No. 113-01, Signing of Death certificates and Release of Remains and Autopsy Procedures". Those cases meeting criteria as Medical Examiner's cases per policy will be referred to the appropriate County Medical Examiner's Office in accordance with state statutes.

vi) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes.

I. Standard precautions will be vigorously enforced for preventing transmission of infectious diseases.

4. PHYSICIANS' ORDERS *

A. General Requirements

i) Orders are entered into the electronic medical record (EMR).

ii) Verbal orders are prohibited except in emergency situations and follow HSP No. 11-16.

iii) Telephone orders will be accepted when the provider is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS. They will be accepted by Registered Nurses, Pharmacists, Physician Assistants, Advanced Practice Nurses, Certified Registered Nurse Anesthetists as designated by facility policy and when it clearly is in the best interest of patient care and efficiency. Appropriate staff receiving the order telephonically will first write down the verbal order and read back the order to the physician to ensure correctness. Verbal/telephone orders will be entered by the nurse or pharmacist and signed electronically by the physician within 24-hours or the next working day whichever is earlier.

B. Medication Orders

i) All drugs used in the Facility must be on the National Formulary and additions as approved by the VISN Pharmacy and Therapeutics (P&T) Committee or be Investigational Drugs that have been approved by the Research and Development Committee and the Facility P&T committee. Exceptions to the foregoing requirements may be made in use of "provisional drugs" or "non-formulary drugs" which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN level. Exceptions are based on an individual patient case by case basis.

ii) All drugs used in the Facility will be stored and dispensed by the Pharmacy.

iii) <u>Duration of Orders</u>:

(a) Schedule II controlled drugs will be written for periods not to exceed fourteen (14) days for in-patients and must be reentered by electronic entry into EMR for each succeeding period of 14 days or less.

(b) Schedule III – V controlled drugs may be written for a period not to exceed thirty (30) days.

(c) Antibiotics orders must include the duration of the therapy.

(d) Orders for all other drugs will be written for a period not to exceed thirty (30) days from the date the first medication was ordered before they expire and must be rewritten.

iv) Ambulatory Care Medication Orders:

(a) All prescriptions must be entered electronically except for Schedule II Controlled Substances.

(b) All prescription controlled substances will follow VHA Handbook 1108-1.

(c) Ninety (90) days is the maximum duration for applicable outpatient prescriptions.

(d) The number of refills authorized on a single prescription may not to exceed one year.

v) Domiciliary Care Medication Orders:

(a) All prescriptions must be entered electronically.

(b) Controlled substances are limited to a 7 day supply.

(c) Thirty (30) days is the maximum duration for Domiciliary Care prescriptions

vi) Transfer of Patients: When a patient is transferred from one level of care to another level of care, or there is a change in physician of record, orders must be written for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.

C. Standardized Order Sets (protocols): Standardized order sets are reviewed periodically by Section or Service Chief and modified as needed. All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by medical staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief.

D. Investigational Drugs: Investigational drugs will be used only when approved by the appropriate Research and Development Committee and the P&T Committee and administered under approved protocol with patient informed consent, under the direct supervision and legitimate order of the authorized Principal Investigator or designated investigator.

E. Informed Consent:

i) Informed consent will be consistent with legal requirements and ethical standards, as described in Facility Policy Informed Consent.

ii) Evidence of receipt of Informed consent, documented in the medical record, is necessary in the medical record before procedures or treatment for which it is required.

F. Submission of Surgical Specimens:

i.) All specimens surgically removed shall be sent to the Histology/Pathology Laboratory. The only exception to the above rule is routine dental extractions. Those specimens are kept by Dental Service. The pathologist shall make such examinations as are necessary to arrive at a pathologic diagnosis. He/she shall prepare and sign an appropriate report containing the findings.

ii.) When diagnosis are based on pathologic interpretations made at outside institutions, slides and/or specimens will be requested from those institutions, re-examined, and reported on by pathologists at this HS prior to instituting treatment.

iii.) Exceptions to sending specimens removed at surgery will be defined by the Pathology and Laboratory Medicine Section and approved by the MEC upon yearly review.

G. Special Treatment Procedures:

i) DNR (Do Not Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment.

(a) A description of the role of the physician, family members and when applicable, other staff in decision.

(b) Mechanisms for reaching decisions about withholding of resuscitative services, including mechanisms to resolve conflicts in decision making.

(c) Documentation in the medical record.

(d) Requirements are described in facility policies, Medical Staff Bylaws, and these Rules.

ii) Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and may be utilized only within the guidelines of an established protocol in the center policy related to Sedation/Analgesia and according to approved privileges. Only by those Practitioners with approved and current privileges to do so.

5. ROLE OF ATTENDING STAFF *

A. Supervision of Residents and Non-Physicians (*Resident Supervision – VHA Handbook 1400.1)*

i) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities.

ii) Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment.

iii) Direct the care of the patient, ensure the quality of that care, and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the

complexity of care, and the experience and judgment of the resident being supervised.

iv) Meet the patient early in the course of care

v) Participate in attending rounds: Participation in rounds does not require that the staff physician or practitioner see every patient in person each day. It does require physical presence of the staff practitioner in the HS for sufficient time to provide appropriate supervision of residents. A variety of face-to-face interactions such as chart rounds, x-ray review sessions, pathology reviews, pre-op reviews, or informal patient discussions fulfill this requirement. In most cases, in acute care settings, face-to-face contact between the staff practitioner and residents should take place in a manner that will ensure optimal patient care. If the attending is unable to be present, another appropriately privileged physician or practitioner may substitute

vi) Assure that all technically complex diagnostic and therapeutic procedures that carry a significant risk to the patient are:

(a) Medically indicated.

(b) Fully explained to the patient.

(c) Properly executed

(d) Correctly interpreted

vii) Evaluated for appropriateness, effectiveness, and required follow-up.

viii) Assure that all high risk or technically complex treatment (such as anti-arrhythmia medications, chemotherapy, radiation therapy, electroconvulsive therapy, and the withholding/withdrawal of life-sustaining treatment, etc.) is:
(a) The appropriate therapy.
(b) Properly prescribed/ordered.
(c) Properly initiated or executed.
(d) Monitored as appropriate.

ix) Direct appropriate modifications of care as indicated in response to significant changes in diagnosis or patient status.

x) Assure that the appropriate information is present within the patient's medical record at the time of transfer to another service, or upon receipt of a patient from another service.

xi) Assure that discharge or transfer of the patient from a ward or clinic is appropriate, based on the specific circumstances of the patient's diagnosis and treatment. The patient will be provided appropriate information regarding the prescribed therapeutic regimen, including specifics on his/her physical activity, diet, medications, functional status, and follow-up plans.

xii) Must be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time, if needed. Each HCG will publish, and make available "call schedules" indicating the responsible staff physician or practitioner (attending) to be contacted.

xiii) When supervising house officers the attending physician must ensure that duties requested of residents are consistent with graduated levels of

responsibility, as defined by ACGME requirements and implemented by affiliated programs.

xiv) Mechanisms by which non-physician members are supervised by the Medical Staff are further stated in the appropriate sub-sections of these Rules.

xv) Psychology interns will be supervised according to standards as set forth by the American Psychological Association, Office of Accreditation.

B. Documentation of Supervision of Resident Physicians

i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.

ii) Entries in the medical record made by residents or those non-physicians (e.g., PAs, ARNPs, etc.) that require countersigning by supervisory or attending medical staff members are covered by appropriate Facility policy and include:

(a) Medical history and physical examination.

(b) Discharge Summary.

(c) Operative Reports.

(d) Medical orders that require co-signature.

(1) DNR.

(2) Withdrawing or withholding life sustaining procedures.

(3) Certification of brain death.

(4) Research protocols.

(5) Investigational drug usage, ONLY permitted by named principal investigators or co-investigators previously designated in the study.

(NOTE: Because medical orders in EMR do not allow a second signature (co-signature), the attending must either write the order for (1) through (5) above; or in an urgent/emergency situation, the house staff or non-physician must obtain verbal concurrence from the attending, document in the progress notes the discussion and concurrence, and can write and sign the order. The attending medical staff member must then co-sign the progress note noting the discussion and concurrence .within 24 hours.)

iii) Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned levels of responsibility. These

activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising Practitioner over and above standard setting-specific documentation requirements (VHA Handbook 1400 page 6).

C. Designated administrative staff will be authorized to make administrative entries as approved by the Chief of Staff. These administrative entries can be for the purposes of: (1) creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering notes to disposition consultation requests and (5) completing other requirements as requested by the Chief of Staff or his/her designee.

6. MEDICAL RECORDS *

A. Basic Administrative Requirements:

i) Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify author, may include written signatures.

ii) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Mid-Level Practitioners.

iii) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in related Facility policy, and is available in CPRS and VISTA. Those abbreviations are not acceptable for use either handwritten or in the EMR.

iv) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.

v) Release of information is required per policy and standard operating procedures for the Facility. (*Privacy & Release of Information Handbook – VHA Handbook 1605.1)*

vi) All medical records are confidential and the property of the Facility and shall not be removed from the premises without permission (ROI from the Patient/consultation with the privacy officer as appropriate). Medical records may be removed from the Facility's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.

vii) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

viii) Progress notes may be made by medical students for educational purposes only; such entries of whatever kind must be countersigned by a licensed physician. Co-signing alone is not sufficient documentation of supervision of

students or acceptable for patient care or billing purposes (per OAA). For clinical purposes, students may serve as transcribers only and the accuracy of their transcription must be verified by the signature of the individual quoted. Medical students will indicate their status by the initials "MS", followed by a numeral designating their year in school, e.g., MS 1, MS 2, MS 3, or MS 4.

B. All Medical Records must contain:

i) Patient identification (name, address, DOB, next of kin).

ii) Medical history including history and details of present illness/injury.

iii) Observations, including results of therapy.

iv) Diagnostic and therapeutic orders.

v) Reports of procedures, tests and their results.

vi) Progress notes.

vii) Consultation reports.

viii) Diagnostic impressions.

ix) Conclusions at termination of evaluation/treatment.

x) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in Facility Policy Memorandum "Informed Consent."

C. Inpatient Medical Records: In addition the items listed in section B above, all inpatient records must contain, at a minimum:

i) A history that includes chief complaint, history of present illnesses, childhood illnesses,, adult illnesses, operations, injuries, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, chief complaint, and review of systems;

ii) A complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self care, mentation, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient assessed personal history. Key examination medical impressions will be documented in the note. The note must be authenticated by provider at the earliest possible time, but always within 24 hours of being written in CPRS.

(a) If the H&P was completed prior to the admission or procedure, it must be updated the day of admission. If it is more than 30 days old, a new one must be completed.

(b) Inpatient H&P must be completed within 24 hours, 48 hours for long term care; and 7 days for the Domiciliary

iii) A discharge plan (from any inpatient admission or Domiciliary), including condition on discharge.

iv) Have a discharge summary (from inpatient or Domiciliary) dictated no later than the day of discharge.

v) Completed within 30 days of discharge.

D. Outpatient Medical Records: In addition the items listed in section B above, all outpatient records must contain, at a minimum:

i) A progress note for each visit.

ii) Relevant history of illness or injury and physical findings including vital signs.

iii) Patient disposition and instruction for follow-up care.

iv) Immunization status, as appropriate.

v) Allergies.

vi) Referrals and communications to other providers.

vii) List of significant past and current diagnoses, conditions, procedures, drug allergies,

viii) Medication reconciliation, problem, and any applicable procedure and operations on the Problem List

E. Surgeries and Other Procedures:

i) All aspects of a surgical patient's care, including ambulatory surgery, pre-operative, operative and post-operative care, must be documented. Surgical interventions, diagnostic procedures, or other invasive procedures must be documented to the degree of specificity needed to support any associated coding data and to provide continuity of care.

ii) Preoperative Documentation:

(a) In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising or staff Practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed; discussion with the patient and family of risks, benefits, potential complications; and alternatives to planned surgery and signed consent

(b) Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical or Subjective/Objective/Assessment/Plan (SOAP) note addressing pertinent positive/negative information, indications for the procedure, known risks related to the procedure, and a physical exam pertinent to the procedure. A formal consultation to the service for performing the

procedure that includes all required content will serve as an H&P if done w/in 30 days, but must be updated the day of the procedure.

(c) Except in an emergency, no patient may go to the operating room without a complete history and physical examination recorded in his/her chart plus recorded results of lab work and x-rays.

(d) A surgical operation shall be performed only with documented informed consent of the patient or his/her legal representative except in emergencies at which time the Chief of Staff holds jurisdiction.

iii) Immediate Post-Operative Documentation: A post-operative progress note must be written, or directly entered into the patient's health record, by the surgeon immediately following surgery and before the patient is transferred to the next level of care.

(a) The immediate post-operative note must include:

(1) Pre-operative diagnosis,

(2) Post-operative diagnosis,

(3) Technical procedures used,

(4) Surgeons,

(5) Findings,

(6) Specimens removed, and

(7) Complications.

(b) The immediate post-operative note may include other data items, such as:

(1) Anesthesia,

(2) Blood loss,

(3) Drains,

(4) Tourniquet Time, or

(5) Plan.

iv) Post-Operative Documentation: An operative report must be dictated and completed by the operating surgeon immediately following surgery. Immediately means upon completion of the operation or procedure, before the patient is transferred to the next level of care. The body of the report needs to contain the: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative diagnosis; names of the supervising Practitioner, primary surgeon, and assistants; and the presence and/or involvement of the supervising Practitioner.

v) Post Anesthesia Care Unit (PACU) Documentation:

(a) PACU documentation must include the patient evaluation on admission to, and discharge from, the post-anesthesia care unit, a time-based

record of vital signs and level of consciousness (either paper or electronic), all drugs administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post-procedural complications, and post-anesthesia visits.

(b) The health record must document the name of the LIP responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.

(c) For inpatients, there needs to be at least one documented post-anesthesia visit after leaving the post-anesthesia care unit. The note needs to describe the presence or absence of anesthesia-related complications.

(d) For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery, to assess any complications, including anesthetic complications, as appropriate.

7. INFECTION CONTROL *

A. Isolation is described in Infection Control Policy

B. Standard Precautions are described in Infection Control Policy

C. Reportable Cases are described in Infection Control Policy

8. CONTINUING EDUCATION *

All Medical Staff members shall participate in their own individual programs of continuing medical education (CME) in order to keep themselves informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care, to refresh them in various aspects of their basic education, and to meet requirements for re-licensure. Medical Staff members are responsible to see that their own participation in continuing education programs and conferences both in and outside the Facility are documented and verifiable at the time of reappraisal and re-privileging.

9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM *

The VHA recognizes its responsibility to assist impaired professionals and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for physicians and dentists.

A. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Chief or Chief of Staff.

B. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment as recommended by the

California State Licensing Board or the Professional Board of the State in which the Provider is licensed.

C. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable hospital policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational Health Program or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.

D. VA and Facility policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for physicians, dentists, and other healthcare professionals.

E. Confidentiality of the Practitioner seeking referral or referred for assistance will be kept, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.

F. The hospital will sponsor periodic educational program regarding illness and impairment issues. Licensed Independent Practitioners will be issued written information regarding illness issues at the time of initial appointment and re-appointment to the medical staff.

10. PEER REVIEW *

<***NOTE***: *Please refer to the following resource when considering changes to this section*: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1638>

A. All Medical Staff members shall participate in the facility protected peer review program established by the appropriate VHA policy.

B. All Medical Staff members will complete ongoing required training associated with the associated VHA policy.

11. Role of Non-Medical Staff Providers

A. Role of Resident House Staff (House Officers): Post-graduate medical students (PGY-1 to PGY-6).

i) The duties and responsibilities of the house officers will be regulated by the Medical Staff, in keeping with the principle of graduated responsibility in training, as defined by ACGME requirements and implemented by the affiliated program.

ii) House Officers will be supervised in the performance of invasive procedures or surgical operations as set forth in VHA Handbook 1400.1 "Resident Supervision."

iii) For elective and scheduled procedures, the staff physician or staff practitioner will evaluate the patient and write a pre-procedure note describing the findings, diagnosis, plan of treatment, and /or choice of specific procedures to be performed.

iv) It is incumbent upon House Officers to seek advice and guidance from the staff as appropriate. It is incumbent upon the staff, to ensure that the medical record shows that such guidance has been provided.

v) Care given the patients on wards and in clinics will be supervised by the attending staff including consultants and contract physicians. Such staff will be identified by name in the medical record.

vi) As noted elsewhere in these Bylaws and Rules, House Officers may write orders, request consultations, order diagnostic tests, prescribe medications, and make other entries in the medical record based on the clinical needs of the patient, but when complete definitive physical examination and histories, together with a diagnostic and therapeutic plan, are prepared and recorded by unlicensed House Officers, these data will be verified and attested to by the addendum and cosignature of a physician member of the Medical Staff.

vii) All discharge summaries will be approved by Medical Staff physicians and dentists as provided in DVA policy.

viii) Nothing shall preclude the right of staff physicians to write orders for patients whether or not House Officers are involved in the care of such patients.

ix) House Officers have the responsibility to provide feedback to the Program Coordinator, Chief of the HCG, or Associate Chief of Staff for Education Resources and Affiliations regarding their assessment of how care is provided in this HS. House Officers have the duty to provide information to these responsible individuals if they perceive a deficiency in patient care.

B. Role of Nurse Practitioners

i) Nurse practitioners will function in VHA settings in keeping with established program guides and other Headquarter Directives such as VHA Directive 2003-004 “Establishing Medication-Prescribing Authority for Clinical Nurse Specialists, Nurse Practitioners, Clinical Pharmacy Specialists and Physician Assistants” of January 28, 2003. Nurse practitioners function according to their defined scope of practice as permitted by state of licensure and individualized through the credentialing and privileging process, as well as in collaboration with physicians and other health care providers. The nurse practitioner is accountable for the delivery of comprehensive health and preventive care services across the spectrum of clinical settings. The nurse practitioner functions primarily as a direct care provider, but activities may include education, research, consultation, and administration.

ii) Nurse practitioners may take histories, perform physical examinations and other appraisals of patients, request consultations, order diagnostic tests,

prescribe medications, as well as arrive at a diagnosis. H&Ps requiring physician review include those for pre-surgical, acute inpatient, SCI, and NHCU patients. These H&Ps will be reviewed by and attested to by an addendum and countersignature of a physician member of the Medical Staff. Nurse practitioners may order diagnostic procedures, medical supplies, initiate and evaluate plans of care and manage patients under “Standardized Procedures” without direct supervision of a physician. Nurse practitioners, who have been specifically designated according to their credentials, may prescribe from the HS Formulary without co-signature. Nurse practitioners are responsible for all activities performed independently.

C. Role of Physician Assistants

i) Physician Assistants will function in VHA settings in keeping with established program guides and other Headquarter Directives such as VHA Directive No. 2001-082 "Medication-Prescribing Authority for Clinical Nurse Specialists, Nurse Practitioners, Clinical Pharmacy Specialists and Physician Assistants" of December 31, 2001. The responsibility of the Medical Staff for the direct medical care of patients will not be abrogated. All physician assistants will be assigned an individual physician supervisor (for each clinical assignment). Physician assistants, when supervised by the Medical Staff, may perform H&P's, and appraisals of patients, as well as arrive at diagnostic formulations. All of these acts will be reviewed and attested to by an addendum and countersignature of a physician member of the Medical Staff. Orders for invasive procedures written by physician assistants will not be honored until validated by the countersignature of a physician.

ii) Physician Assistants, under the scope of practice granted by the chief of the HCG, may prescribe a limited formulary without co-signature. This limited formulary will be agreed upon in advance and approved by the MEC.

iii) Physician assistants may make ongoing entries in progress notes in their own name. Those activities of physician assistants relating to medical care on any clinical unit will be the responsibility of the physician assigned to that unit. The delineation, description, and monitoring of physician assistants, will be described under the scope of practice and be part of the performance plan and position description. Because of individual variations in experience, these elements will be decided individually based upon approved criteria developed by each service to which the physician assistants are assigned. Such criteria will address routine duties, non-routine but non-emergency duties, and the manner in which physician assistants will act as agents of supervising physicians. None of this is intended to imply the independent practice of medical activities by physician assistants.

D. Role of Clinical Pharmacy Specialists

i) Clinical pharmacy specialists will function in VHA health care settings in keeping with established program guidelines and other Headquarters

directives, such as the VHA Directive 2001-082 "Medication-Prescribing Specialists, Nurse Practitioners, Clinical Pharmacy Specialists, and Physician Assistants" of December 31, 2001.

ii) The scope of practice for clinical pharmacy specialists, which includes direct patient care activities and prescribing authority for a designated formulary, must be approved by a sponsoring physician, the Licensed Pharmacist Professional Standards Board and the Chief of Staff.

E. Role of Certified Registered Nurse Anesthetists

i) Certified Registered Nurse Anesthetists (CRNA) will be assigned to the Surgical and Interventional HCG, Anesthesiology Service and function under the direct supervision of anesthesiologists in accordance with VHA policy and congruent with applicable law. Because of the complex nature of anesthetic administration, and in order to ensure that such individuals perform only those procedures and use such agents and modalities that are acceptable to the scope of practice, they will be processed and approved in a manner analogous to the privileging of physicians, including the use of approved criteria formulated by the Anesthesiology Section. The delineation and description of the activities of nurse anesthetists will be described in the position description and closely monitored at the section level. None of this is intended to imply the independent practice of medical activities by nurse anesthetists.

F. Role of New Categories of Providers

i) When other or new categories of providers desire to participate in clinical activities or perform services that require surveillance by the Medical Staff, requests and criteria for such activities will be prepared by their service and evaluated on the service level. The service will make recommendations to the MEC concerning such matters. Any such extension of practice will be subject to ratification by the MEC and the HS Director, and shall meet or exceed established VHA standards. Local policy may be made more (but not less) restrictive than the DVA policy when considered necessary by the Medical Staff and the HS Director.

G. Role of Other Health Care Providers

i) A wide variety of other health care professionals function in this HS within established professional, legal, and DVA policies. These individuals will not be individually permitted to engage in clinical activities, except within their desired designated scope of practice

Adopted by the Medical Staff, Veterans Affairs Medical Center, Long Beach, ____ Day of _____2013.

RECOMMENDED

/s/ Norman Ge, MD — 8/14/13

Norman N. Ge, MD, FACS — Date

Interim Chief of Staff

APPROVED

/s/ Cynthia Abair — 10/3/13

Isabel Duff, MS — Date

Director