ST. CLOUD VA HEALTH CARE SYSTEM

HEALTH CARE SYSTEM MEMORANDUM CD 11-05 April 2013
Updated August 2013

BYLAWS, RULES, AND REGULATIONS OF THE MEDICAL AND CLINICAL PROFESSIONAL STAFF

SUMMARY OF CHANGES

Bylaws and rules provide guidance to medical staff members to assist them to meet the expectations of the Medical Staff and to comply with VA, VHA, The Joint Commission and local facility requirements and expectations. They provide the framework that will allow medical staff members and applicants to knowledgeably agree to abide by the rules and policies of the medical staff.

Discharge summary timeframes for death or irregular discharge for inpatients and for Community Living Center and Mental Health Residential Rehabilitation treatment patients, within Medical Staff rules; III. Responsibility of Care

Moved APRN/PA documentation requirements for physician citation to page 58 from page 59

Updated the inpatient/resident medical records section under Medical Staff Rules; VI. Medical Records

Table of Contents

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 Health Care System, St. Cloud, MN, hereinafter sometimes referred to as St. Cloud VAMC, 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.

St. Cloud VAMC comprises inpatient and long-term care services, residential behavioral health services, home care services, outpatient clinics, and Minnesota community-based outpatient clinics in Brainerd, Alexandria, and Montevideo. Portions of these bylaws are required by the 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.

MISSION

As part of the VA Upper Midwest Health Care Network, the St. Cloud VA Health Care System's mission is to honor America's Veterans by providing exceptional health care that improves their health and well-being.

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. **Associate Director of Patient Care Services/ Nurse Executive/ (ADPCS /NE/):** The ADPCS/NE 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 Counsel (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.

4. **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: Pharmacists (PharmDs), psychologists, podiatrists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.

5. **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 recommended by the Professional Standards Board and endorsed by the Medical Executive Board.

6. **Chief of Staff:** The Chief of Staff is the President of the medical staff and Chairperson of the Medical Executive Board 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.

7. **Clinical Privileges:** Specific diagnostic and/or therapeutic services for which permission to render has been requested by the practitioner and for which such permission has been granted based on the requestor's license, education, training, experience, competence, health status, and judgment by the Health Care System Director with recommendation of the Professional Standards Board and endorsement of those recommendations by the Medical Executive Board. Clinical Privileges are granted to Physicians, Dentists, Optometrists, and Podiatrists only.

8. **Collaboration:** Cooperative arrangement in which two or more clinical professionals work jointly towards the common goal of providing safe, high-quality, patient care. Collaborative relationships are signified by working together to evaluate specific patient or population conditions, share knowledge and provide care consistent with accepted clinical standards.

9. **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

10. **Continuous Improvement Program:** An ongoing Health Care System management approach designed to objectively and systematically monitor, evaluate, and study the quality and appropriateness of patient care and the needs of others, pursue ways to improve patient care, and resolve identified problems. Performance improvement clinical reviews/clinical monitoring activities are reviewed by either the Medical Executive Board or Quality Leadership Council as appropriate.

11. **Facility Director:** The Director is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Associate Director, Chief of Staff (COS) and the Associate Director for Patient Care Services/Nurse Executive/ (ADPCS/NE), and the Medical Executive Board.

12. **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.

13. **Licensed Independent Practitioner:** The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the St. Cloud VAMC 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 and dentists. It may also include individuals who can practice independently, who meet this criterion for independent practice. For the purposes of these Bylaws, LIP refers to physicians, dentists, podiatrists, and optometrists only.

14. **Medical Executive Board (MEB):** A group of individuals, a majority of whom are licensed physician members of the Medical Staff practicing in the organization, selected by the Medical Staff or appointed in accordance with medical staff bylaws. This group is responsible for making specific recommendations directly to the organization's

governing body for approval, as well as receiving and acting on reports and recommendations from medical staff committees, clinical departments or services, and assigned activity groups.

15. **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. This body may include others, such as retired Practitioners who no longer practice in the organization but wish to continue their membership in the body. The medical staff includes both members of the organized medical staff and non-members of the organized medical staff who provide health care services.

16. **Mid-Level Practitioner:** Mid-Level Practitioners are those health care professionals who are not physicians and dentists and who function within a Scope of Practice but may practice autonomously within defined Scopes of Practice as defined in these Bylaws. Mid-Level Practitioners include: physician assistants (PA), and Advanced Practice Registered Nurses (APRN). Mid-Level Practitioners may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations. PAs function under the supervision of a credentialed and privileged physician. APRNs function autonomously with an assigned collaborating physician. Mid-Level Practitioners do not have admitting privileges, but may complete admission orders and physical examinations as outlined within their specific Scope of Practice. Mid-Level Practitioners may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations.

    a. **Advanced Practice Registered Nurse (APRN):** As used in this document refers to a registered nurse having education beyond the basic nursing education and certified by a nationally recognized professional organization in a nursing specialty, or meeting other criteria established by a Board of Nursing. The Board of Nursing establishes rules specifying which professional nursing organization certifications can be recognized for advanced practice nurses and sets requirements of education, training, and experience. Designations recognized as advanced practice nursing include certified registered nurse anesthetist, clinical nurse specialist, and nurse practitioner.

    b. **Physician Assistants (PA):** As used in this document refers to those who have a bachelor's degree from a PA training program, which is certified by the Committee on Allied Health Education and Accreditation (CAHEA); or PA training program of at least 12-months duration certified by the CAHEA and a bachelor's degree in health care occupation or a health related science; or graduation from a PA training program of at least 12-months duration with a CAHEA certification and a period of progressively responsible health care experience such as an independent duty medical corpsman, licensed practical nurse, registered nurse, medical technologist or medical technician. The duration of approved academic training and health care experience must total at least five years. In addition to the above, PA's are required to have certification by the National Commission on Certification of Physician's Assistants.

17. **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/Scope of Practice. The Organized medical staff is comprised of Physicians, Dentists, Optometrists, and Podiatrists only.

18. **Outpatient Clinic:** An outpatient clinic is a healthcare site whose location is independent of medical facility, however; oversight is assigned to a medical facility.

19. **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.

20. **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.

21. **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.

22. **Professional Standards Board (PSB):** The Professional Standards Board acts as a Credentials Committee on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matters to the Medical Executive Board as defined in these Bylaws. This board may also make action recommendations on matters involving Associated Health and Mid-Level Practitioners such as granting prescriptive authority, defining scopes of practice, and appointment. Some professional standards boards (e.g. Nursing, Psychology, Social Work, etc) are responsible for advancement and other issues related to their respective professions.

23. **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 Medical Executive Board and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.

24. **Scope of Practice :** Specific diagnostic and/or therapeutic services for which permission to render has been requested by the non-physician practitioner or Associated health professional and for which such permission has been granted based on the requestor's license, education, training, experience, competence, health status, and judgment of the Health Care System Director with recommendation of the Professional Standards Board and/or endorsement of the Medical Executive Board.

25. **Supervision:** Overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required so long as the physician assistant can easily contact the supervising physician or another fully licensed physician by radio, telephone, or other telecommunication device. Supervising physicians are assigned as noted on the Physician Assistant scope of practice. Supervising physicians evaluate assigned PA performance and provide information to be considered with the issuance, renewal or modification to the PA's scope of practice.

26. **Teleconsultation:** The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent practitioner to another licensed independent practitioner or mid-level practitioner 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 health care practitioner.

27. **Telemedicine:** The provision of care by a licensed independent health care practitioner or mid-level practitioner that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the practitioner and the patient.

28. **VA Regulations:** The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws. (i.e. VA or VHA Handbooks, VA or VHA Directives, VA or VHA Memorandums, etc.)

ARTICLE I. **NAME**

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, VA Health Care System, St. Cloud, Minnesota

ARTICLE II. **PURPOSE**

The purposes of the Medical Staff shall be to:

1. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.

2. 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.

3. Establish and assure adherence to ethical standards of professional practice and conduct.

4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.

5. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.

6. 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.

7. Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.

8. Provide a medical perspective, as appropriate, to issues being considered by the Governing Body.

9. 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.

10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.

11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.

12. 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 trainees.

13. 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.

14. Coordinate and oversee the scope of practice of all Mid-Level and appropriate Associated Health Practitioner staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each Mid-Level and appropriate Associated Health Practitioner should have a scope of practice statement as well as the means employed to coordinate their function with the medical staff.

ARTICLE III. **MEDICAL STAFF MEMBERSHIP**

The Medical Staff includes the Organized Medical Staff and mid-level practitioners. Throughout the remainder of this document, Medical Staff shall reference both groups collectively unless Organized Medical Staff are specifically cited.

Section 3.01 Eligibility for Membership on the Organized Medical Staff

1. Membership: Membership on the Organized Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, dentists, podiatrists, and optometrists, who continuously meet the qualifications, standards, and requirements set forth by the VHA, and VA Health Care System, St. Cloud, MN, in these Bylaws.

This includes full-time, part-time, fee-per-visit (on station contract), and without compensation status, including consultants.

2. Categories of the Organized Medical Staff: Membership rights and responsibility are based on the following categories to which the member is appointed:

   a. Category I - Full-time staff: Staff members who are actively practicing within, and employed by VA Health Care System, St. Cloud, on a full-time permanent basis, and any who hold official administrative appointments. Members shall be appointed to a specific service, shall be eligible to vote and to serve on Organized Medical Staff committees. Members shall take a leadership role in the oversight of the quality of care, treatment and service. Attendance at 50% of the Organized Medical Staff meetings is required, unless formally excused.

   b. Category II - Part-time staff: Staff members who are actively practicing within and employed by the VA Health Care System, St. Cloud, on a less than full-time, permanent basis, but equal to or greater than a half-time basis. Members shall be appointed to a specific service, shall be eligible to vote and to serve on Organized Medical Staff committees. Attendance at 50% of the Organized Medical Staff meetings is required, unless formally excused.

   c. Category III - Less than half-time staff: Staff members who are actively practicing within and employed by the VA Health Care System, St. Cloud, on a less than half-time, permanent basis. Members may or may not be appointed to a specific service and may serve on Organized Medical Staff committees. Members are not eligible to vote. Attendance at Organized Medical Staff meetings is voluntary.

   d. Category IV – Associate staff: Staff members practicing within, and employed by the VA Health Care System, St. Cloud through a non-permanent status such as Fee Basis, Consultant, Contract, etc. Members may or may not be assigned to a specific service and may serve on Organized Medical Staff committees. Members are not eligible to vote. Attendance at Organized Medical Staff meetings is voluntary.

3. Decisions regarding Organized Medical Staff membership 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.

Section 3.02 Eligibility for Membership on the Medical Staff

1. Membership: In addition to the Organized Medical Staff members as defined in Section 3.01 above, membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent advanced practice registered nurses (APRN) and Physician Assistants (PA) who continuously meet the qualifications, standards, and requirements set forth by the VHA, and St. Cloud VA Health Care System, and these Bylaws. This includes full-time, part-time, fee-per-visit (on station contract), and without compensation status, including consultants.

2. Categories of the Medical Staff: Membership rights and responsibility are based on the following categories:

   a. Category I - Full-time/Half-time staff: Staff members who are actively practicing within, and employed by VA Health Care System, St. Cloud, on either a full-time, or at least half-time, permanent basis. Members shall be appointed to a specific service and may be elected or appointed to serve on committees. Members shall support Organized Medical Staff in oversight of the quality of care, treatment and service. Attendance at assigned committees is mandatory, unless formally excused. Attendance at Organized Medical Staff meetings is voluntary. Members are not eligible to vote at Organized Medical Staff meetings and will be excused from those meetings where Organized Medical Staff members have voting obligations.

   b. Category II - Less than half-time staff: Staff members who are actively practicing within and employed by the VA Health Care System, St. Cloud, on a less than half-time, permanent basis. Members may or may not be appointed to a specific service and may be appointed to serve on committees. Members are not eligible for election to medical staff committees. Attendance at appointed committee meetings is mandatory, unless formally

excused. Attendance at Organized Medical Staff meetings is voluntary. Members are not eligible to vote at Organized Medical Staff meetings and will be excused from those meetings where Organized Medical Staff members have voting obligations.

c. Category III – Associate staff: Staff members practicing within, and employed by the VA Health Care System, St. Cloud through a non-permanent status such as Fee Basis, Consultant, Contract, etc. Members may or may not be assigned to a specific service and are not appointed or elected to committees. Attendance at Organized Medical Staff meetings is voluntary. Members are not eligible to vote at Organized Medical Staff meetings and will be excused from those meetings where Organized Medical Staff members have voting obligations.

3. Decisions regarding Medical Staff membership 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.

Section 3.03 Qualifications for Medical Staff Membership and Clinical Privileges/Scope of Practice

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. 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 Doctoral level degree in Medicine, Osteopathy, or Dentistry from an approved college or university. Mid-level staff must meet education requirements as cited in definitions section of this document.

c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges/scope of practice for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training.

d. Current competence, consistent with the individual's assignment and the privileges/scope of practice for which he/she is applying.

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

f. Complete information consistent with requirements for application and clinical privileges/scope of practice as defined in Articles VI or VII of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff.

g. Satisfactory findings relative to previous professional competence and professional conduct.

h. English language proficiency.

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

j. 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
        iii) Podiatrists
        iv) Optometrists

    b. The following Practitioners will be credentialed and may be granted a Scope of Practice to practice autonomously if in possession of State license/registration that permits autonomous practice and authorized by this Facility:

        i) Doctors of Pharmacy
        ii) Clinical Pharmacists
        iii) Psychologists
        iv) Licensed Independent Social Workers
        v) Registered Dieticians

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

        i) Physician Assistants

    d. The following Practitioners will be credentialed and will practice under a Scope of Practice with an assigned collaborating physician:

        i) Advanced Practice Registered Nurses

3. Change in Status: Members of the Organized Medical Staff as well as all Practitioners practicing within 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, the ability to carry out Scope of Practice duties, 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 to the involved practitioner.

4. Termination of Medical Staff membership:

    a. Medical Staff membership will be terminated upon resignation unless request for continued membership has been presented and approved by the Chief of Staff.

    b. Indications for membership termination shall include, but are not limited to:
        i) Failure to follow the requirements of the Bylaws of the Medical Staff
        ii) Failure to adhere to the Rules and Regulations of the Medical Staff
        iii) Reduction or revocation of privileges
        iv) Reduction or revocation of Scope of Practice
        v) Engaging in clinical or interpersonal behavior which is of sufficient import so as to raise the question of improper or substandard clinical conduct or competence.

c. Process for membership termination will be accomplished in conjunction with the procedure for terminating appointments of practitioners set forth in VA Handbook 5021.

Section 3.04 Code of Conduct

1. Demonstrates Leadership: The VA expects that members of the medical staff will serve as leaders to clinical staff through formal or informal mentoring, sharing knowledge, promoting a vision of improved health care, supervising PAs and collaborating with APRNs to ensure that patients receive the highest quality care.

2. 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:

   a. Being on duty as assigned.

   b. Timely response to calls/pages

   c. Responding to internal or external disasters when called in accordance with Disaster Preparedness policies and Service Line callback plans

   d. 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.

   e. 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.

   f. Not making a governmental decision outside of official channels.

   g. Not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government.

   h. 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.

   i. Maintain standard of ethics and ethical relationships that include commitment to:

      i) Abiding by federal law and VHA rules and regulations regarding outside professional activities for remuneration.

      ii) Providing care to patients within clinical privileges/scope of practice and advise the St. Cloud VA Health Care System Director and Chief of Staff of any change in his/her ability to meet fully the criteria for Medical Staff membership or to carry out clinical privileges/scope of practice duties which are held.

      iii) Advising the Health Care System Director of any challenges or claims against professional credentials, professional competence or professional conduct within 15 days of notification of such occurrences and their outcomes consistent with requirements for these Bylaws.

3. Behavior or Behaviors That Undermine a Culture of Safety: VA recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. VA strongly urges its practitioners 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. Practitioners 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.

Behavior or Behaviors That Undermine a Culture of Safety 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 Behavior or Behaviors That Undermine a Culture of Safety 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, Behavior or Behaviors That Undermine a Culture of Safety may reach a threshold such that it constitutes grounds for further inquiry by the PSB/MEB into the potential underlying causes of such behavior. Behavior by a practitioner that is disruptive could be grounds for disciplinary action. VA distinguishes Behavior or Behaviors That Undermine a Culture of Safety from constructive criticism that is offered in a professional manner with the aim of improving patient care. VA also reminds its practitioners of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a practitioner's health and performance. Practitioners suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Practitioners, in their role as patient and peer advocates, are obligated to take appropriate action when observing Behavior or Behaviors That Undermine a Culture of Safety on the part of other practitioners. VA urges its practitioners to support their hospital, practice, or other healthcare organization in their efforts to identify and manage Behavior or Behaviors That Undermine a Culture of Safety, by taking a role in this process when appropriate.

4. 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 3.05: Conflict Resolution & Management

For VA to be effective and efficient in achieving its goals, the organization 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 Medical Executive Board 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. The Governing Body (Director) must determine the method of this communication. 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, Patient Safety Officer, or other individual as described in the following Agency resources:

Office of Diversity and Inclusion (EEO) website at http://www.diversity.hr.va.gov/index.asp

Alternative Dispute Resolution: Memorandum on Alternative Dispute Resolution for Workplace Disputes, (February 8, 2007)

VA Directive 5978, Alternative Dispute Resolution (February 23, 2000)

VA Handbook 5978.1, Alternative Dispute Resolution Program: Central Office (December 11, 2007)

ARTICLE IV: ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. Composition:

   a. Chief of Staff

   b. Service Line Medical Directors

2. Qualifications:

   a. Chief of Staff and each Service Line Medical Director is to possess Board Certification/training by an appropriate specialty board as outlined in VHA directives.

3. Selection:

   a. The Chief of Staff is appointed by the Health Care System Director.

   b. Service Line Medical Directors are appointed by the Health Care System Director based upon the recommendations of the Chief of Staff.

4. Removal:

   a. Chief of Staff may be removed upon recommendation of the Health Care System Director and the VISN 23 Chief Medical Officer in accordance with applicable laws and VA regulations.

   b. Service Line Medical Directors may be removed upon recommendation of the Chief of Staff and approval of the Health Care System Director in accordance with applicable laws and VA regulations.

5. Duties:

   a. Chief of Staff serves as Chairperson of the Medical Staff and Medical Executive Board.

   b. Service Line Medical Directors serve as leaders of their clinical services/departments. (See also section 4.03, paragraph 4)

Section 4.02 Leadership

1. The Organized Medical Staff, through its committees, services and Service Line Medical Directors, 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 Services

1. Characteristics:

   a. Each clinical service line is organized to provide clinical care and treatment under the leadership of the Service Line Medical Director(s). The clinical service lines include: Primary & Specialty Medicine (PSM), Surgery & Specialty Care (SSC), Mental Health (MH), Extended Care & Rehabilitation (EC&R), Pathology & Laboratory Medicine (P&LM), Dental, and Imaging. Medical staff members practicing within a service line/department are subject to the policies and procedures of that service line/department..

b. Medical Staff in the service line will meet regularly and at a minimum quarterly. Minutes will be forwarded to the MEB for review. Service line medical staff will seek MEB action on recommendations through submission of MEB Executive Summary forms.

c. Medical Staff are required to attend 50% of these meetings unless they obtain an excused absence. Medical staff members are responsible for the knowledge/information disseminated during these meetings. Meeting content will be available for review through established mechanisms such as published minutes, e-mail messages, or other forms of communication.

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 to the Medical Executive Board.

d. Develop criteria for recommending clinical privileges or defined Scopes of Practice for members of the Service and ensure that ongoing professional practice evaluation is continuously performed and results are utilized at the time of granting clinical privileges, issuing Scopes of Practice, continuing privileges, continuing Scopes of Practice, re-privileging, re-issuing Scopes, and re-credentialing.

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 and/or autonomous Scope of Practice templates for each Service and make recommendations to PSB for recommendation to MEB and endorsement to Health Care System Director.

3. Selection and Appointment of Service Line Medical Directors: Service Line Medical Directors are appointed by the Director based upon the recommendation of the Chief of Staff.

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

a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as Service Line Medical Director.

b. Clinically related activities of the Service.

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

d. Will verify the qualifications and competence of medical staff applicants through direct contact with references.

e. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges or Scope of Practice through FPPE/OPPE processes.

f. Recommending to the organized medical staff the criteria for clinical privileges/Scopes of Practice that are relevant to the care provided in the Service.

g. Recommending clinical privileges or Scope of Practice for each Medical Staff member of the Service.

h. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the Service and communicating the recommendations to the relevant organizational authority such as Management Advisory Council or Medical Executive Board.

i. The integration of the Service into the primary functions of the organization.

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

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

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

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

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

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

p. The orientation and continuing education of all persons in the service.

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

r. Annual review of all clinical privilege or Scope of Practice 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/Scope of Practice delineation form.

ARTICLE V. MEDICAL STAFF COMMITTEES
Section 5.01 General

1. Committees are either standing or special.

2. Medical Staff members will attend the meetings of committees to which they are assigned, excluding excused absences. Medical Staff Committee minutes will specify members absent, alternates, and members present. It is the responsibility of the Medical Staff member to obtain excused absence.

3. 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.

4. Generally, the presence of 50% of a committee's members will constitute a quorum. In the event of attendance not meeting quorum requirements, the committee may still meet and conduct business, but shall not vote on matters of major clinical significance. The committee will determine those items deemed to have major clinical significance.

5. The members of all standing committees, other than the Medical Executive Board, are appointed by the Chief of Staff subject to approval by the Medical Executive Board, unless otherwise stated in these Bylaws.

6. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff.

7. Only Medical staff members in good standing are permitted to serve on committees. Committee assignment may be terminated at the discretion of the Chief of Staff for members failing to maintain good standing status including, but not limited to licensure, performance and adherence to the conditions set forth in these Bylaws.

8. Robert's Rules of Order Newly Revised will govern all committee meetings.

Section 5.02 Executive Committee of the Medical Staff

(1) Characteristics: The MEB serves as the Executive Committee of the Medical Staff. MEB membership is composed of at least 50% physicians, with a majority being Category I or Category II Organized Medical Staff members. The MEB membership is facility specific as follows:

a) Chief of Staff – Chairperson

b) Primary & Specialty Medicine (PSM)Service Line Medical Director

c) Surgery & Specialty Care (SSC) Service Line Medical Director

d) Mental Health (MH) Service Line Medical Director

e) Dental Service Medical Director

f) Addictions Service Medical Director

g) Extended Care & Rehabilitation (EC&R) Service Line Medical Director

h) Pathology and Laboratory Medicine Service Line Medical Director

i) One at large physician medical staff member *(See voting selection process below)*

j) One appointed Medical Staff member from each of these service lines: PSM, MH, and EC&R. Only Organized Medical Staff member appointees have voting privileges

k) Non-Voting MEB members:

i) One at large mid-level practitioner *(See voting selection process below)*

ii) Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE)

iii) Clinical Pharmacist

iv) Quality Manager

v) Health Care System Director, or designee (Ex Officio), who recuses him/herself from any discussion by the MEB related to consideration for the reduction or revocation of clinical privileges

vi) Administrative Officer to Chief of Staff (Ex Officio)

l) Membership Selection processes:

i) The following are standing members:

(1) Chief of Staff
(2) Primary & Specialty Medicine (PSM) Service Line Medical Director
(3) Surgery & Specialty Care (SSC) Service Line Medical Director
(4) Mental Health (MH) Service Line Medical Director
(5) Dental Service Medical Director
(6) Addictions Service Medical Director
(7) Extended Care & Rehabilitation (EC&R) Service Line Medical Director
(8) Pathology and Laboratory Medicine Service Line Medical Director
(9) Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE)
(10) Clinical Pharmacist
(11) Quality Manager
(12) Health Care System Director, or designee (Ex Officio)
(13) Administrative Officer to Chief of Staff (Ex Officio)

ii) Medical Staff members from PSM, MH, and EC&R are appointed by their respective Service Line Medical Directors

iii) Voting selection process for at-large MEB Members:

(1) One physician Medical Staff member elected by Medical Staff voting members to serve a one year term, who may be elected to serve consecutive terms.

(a) Ballots shall include all eligible physicians and will be distributed at a Medical Staff meeting and electronically. Completed ballots will be returned within one week of the Medical Staff meeting.

(2) One APRN/PA Medical Staff member elected by APRN/PA Medical Staff members to serve a one year term, who may be elected to serve consecutive terms.

(a) Ballots shall include all eligible APRN/PA Medical Staff members and will be distributed at a Medical Staff meeting and electronically. Completed ballots will be returned within one week of the Medical Staff meeting.

m) Removal from MEB:

i) MEB membership will be terminated upon resignation or change in employment status such that the MEB member no longer has Medical Staff voting privileges.

ii) Indications for membership termination shall include, but are not limited to:

(1) Failure to follow the requirements of the Bylaws of the Medical Staff

(2) Failure to adhere to the Rules and Regulations of the Medical Staff

(3) Failure to fulfill committee member obligations

(4) Reduction or revocation of privileges

(5) Engaging in clinical or interpersonal behavior which is of sufficient import so as to raise the question of improper or substandard clinical conduct or competence.

(6) Unacceptable performance or conduct

iii) Recommendations for removal are made by the Chief of Staff and approved by the Director.

n) MEB vacancies: The Chief of Staff will consult the MEB for determining the need to fill a member vacancy and appoint a member to fulfill the term requirement as appropriate.

2. Functions of the MEB: The MEB:

a. Acts on behalf of the Medical Staff between Medical Staff meetings within the scope of its responsibilities as defined by the Organized Medical Staff. Refer to Article XII for requirements related to changes to this document.

b. Maintains oversight of the 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.

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

d. Makes recommendations directly to the Director regarding the:

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

ii) Process used to review credentials and delineate privileges or Scopes of Practice for the medical staff.

iii) Delineation of privileges or Scope of Practice for each Practitioner credentialed.

e. 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 external standards.

f. Oversees process in place for instances of “for-cause” concerning a medical staff member’s competency to perform requested privileges.

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

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

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

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

k. 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.

l. 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.

m. Acts upon recommendations from the Professional Standards Board (PSB).

n. 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 or PSB.

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

p. Annually reviews and makes recommendations for approval of the Service-specific privilege lists/scope of practice elements.

3. Meetings:

a. Regular Meetings: Regular meetings of the MEB shall be held twice monthly or at the call of the Chairperson. The date and time of the meetings shall be established by the Chair. The Chairperson, or designee, of the committees reporting to MEB shall attend regular meetings of the MEB 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 MEB.

b. Emergency Meetings: Emergency meetings of the MEB 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 MEB, 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 MEB members shall be provided 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 designee, shall chair meetings of the MEB. 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 MEB shall be greater than or equal to 25% of the voting medical staff members, with a majority of those members being fully licensed physicians of medicine or osteopathy. Action may be taken by majority vote at any meeting at which a quorum is present.

f. Guests: Others may be invited to the MEB meetings as appropriate for the purpose of providing information or expert opinion. Guests are not granted voting privileges for any MEB decisions and are present only as necessary to address MEB members' questions/concerns for the specified topic. Guest attendance must be approved by the Chair.

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

h. Communication of Action: The Chair of the MEB meeting 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

1. The Organized Medical Staff provides oversight of medical staff appointments; medical staff monitoring activities; and patient care services assuring quality of care, treatment, safety, and services for patients.

2. The Committees have specifically defined charges and 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

   g. Providing and improving Patient Safety

   h. Setting forth additional purposes in the charges to each committee

3. The MEB acts on behalf of the Medical Staff through review and action on reports from the Medical Staff committees and departments.

   a. The MEB has approving authority or oversight of all clinical care committees. These committees include, but are not limited to:

      i) Clinical Bar Code Multidisciplinary Committee (Pharmacy 119-19)
      ii) Clinical Product Review Committee (LOG-03)
      iii) Code Blue Committee (CD11-27)
      iv) Diagnostic, Tissue & Procedures Review Committee (CD11-22)
      v) Facility Behavior Committee (CD11-50)
      vi) Health Promotion and Disease Prevention (HR-05)
      vii) Infection Prevention Committee (CD11-25)
      viii) Information Management (IM) Committee (CD00-47)
      ix) Medical Records & Documentation Committee (CD11-90)
      x) Nurse Executive Council (NEC) (118-01)
      xi) Nurse Professional Practice Council (NPPC) (118-01)
      xii) Pain Management Committee (CD11-68)
      xiii) Patient Care Data Capture (BUS-03)
      xiv) Patient Education Committee (ED-03)
      xv) Peer Review Committee (CD11-12)
      xvi) Pharmacy and Therapeutics Committee (Ph/Pharmacy 119-20)
      xvii) Professional Standards Board (see below)
      xviii) Reusable Medical Equipment (RME) (CD00-50)
      xix) Research and Development (R&D) Committee (CD11-82)
      xx) Surgical/Specialty Care Clinics & Operating Room Committee (SSC\SSC-03)
      xxi) Tobacco Use Committee (CD00-02)
      xxii) Women Veteran Advisory Committee (CD11-30)

4. Medical Staff committees specific to self-governance include, but are not limited to:

a. Professional Standards Board (PSB):

i) Charge: Review applications for appointment to the Medical Staff referred to it by the Chief of Staff or designee(s); review the recommendations of the Chief of Staff and Service Line Medical Directors; conduct personal interviews of candidates at its discretion; conduct a personal interview with the Chief of Staff and/or Service Line Medical Director in instances of disapproval of an application by the Chief of Staff and/or Service Line Medical Director or both. In the event the Committee intends to recommend disapproval, personal interviews may be held with the Chief of Staff and Service Line Medical Director, and if appropriate, with the candidate after written notification to the candidate of the intended disapproval. At least every 6 months, reviews the status and appropriateness of clinical privileges for each medical staff member or when cases are referred by the Chief of Staff or Service Line Medical Director. Reviews are based on performance and quality data as defined in the medical staff member's profile. Reviews and makes recommendation for all new/proposed changes to delineation of clinical privileges or Scopes of Practice; recommend appropriate action to the MEB. Develops and/or approves proposed monitors and triggers for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

ii) Composition: Is chaired by the Chief of Staff or designee. Is comprised of Chief of Staff, Service Line Medical Directors and other medical staff members as recommended by the Service Line Medical Director with concurrence of the Chief of Staff and approval of the Health Care System Director. A quorum is defined as at least 50% of the members present with a majority of physician members. The Credentialing Coordinator is the process owner for PSB work and maintains all schedules and records related to the PSB.

iii) Meetings: Are held bi-monthly or at the call of the Chairperson. Attendance is mandatory unless excused by the Chair. Minutes and specific recommendations for action with supporting evidence are forwarded to the MEB for endorsement to the Health Care System Director. PSB recommendations are in force only after endorsement by the MEB and approval of the Health Care System Director.

b. Peer Review Committee: (HCSM CD 11-12)

i) Charge: Oversight and completion of peer reviews, assuring a consistent, timely, systematic, fair and balanced review process. This is a protected (confidential) review for quality management purposes, to include resource utilization, which is relevant to the care provided by individual practitioners, in support of clinical care programs and professional services, and is intended to improve practitioner decisions. This is an educational/non-punitive process for practitioners to assure quality care. Peer review activities are protected under the confidentiality provisions of Title 38, U.S. Code Section 5705 and its implementing regulations and will be so protected by all those involved in carrying out the policy. If changes in privileges/scopes of practice, personnel actions, demotions, or reassignments are contemplated, information must be developed through mechanisms independent of the peer review process, according to VHA policy and existing medical staff bylaws. If an identified case is being addressed by a root cause analysis, or administrative investigation, the decision to seek additional peer review will be addressed on a case-by-case basis by the Chief of Staff. The investigation findings will need to be addressed with the appropriate Service Line Medical Director.

ii) Composition: All practitioners/professionals will potentially serve as peer reviewers. Medical staff members will be expected to complete required training and serve as peer reviewers as part of fulfilling their medical staff responsibilities. Medical Staff training will be provided by VHA guidelines and documented in training records. Just in time training will be provided at the time of peer review assignment and documented.

iii) Meetings: Monthly

5. Information Flow to MEB: All Medical Staff Committees, including but not limited to those listed above, will submit minutes of all meetings to the MEB in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the MEB. In instances where committee information is protected, such as Peer Review, de-identified summary information shall be submitted.

Section 5.04 Committee Records and Minutes

1. 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 MEB and disseminated to the Medical Staff, on a regular recurring schedule, but at least annually.

2. Each Committee provides appropriate and timely feedback to the Services relating to all information regarding the Service and its practitioners.

3. Each committee shall review and forward to the MEB, a synopsis of any subcommittee and/or workgroup findings on a regular recurring schedule, but at least annually.

Section 5.05 Establishment of Committees

1. The MEB 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 MEB may, by resolution and upon approval of the Director, without amendment of these Bylaws, 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 Organized Medical Staff are generally held monthly, but shall be held at least annually. The Chief of Staff, or designee, may cancel or change a meeting schedule as necessary to accommodate Medical Staff needs. Written notice of meeting schedule changes shall be given to members of the Medical Staff in advance when possible. A record of attendance shall be kept.

2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the MEB. 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% of the Organized Medical Staff membership entitled to vote constitutes a quorum.

    s. Meeting Attendance: Meeting attendance is based on Medical Staff membership category as cited in Article III, Section 3.01 of these bylaws. Category I and Category II Organized Medical Staff members are required to attend 50% of regular Medical Staff meetings unless excused by the Chair. It is the Medical Staff member's responsibility to obtain an excused absence. Medical staff members are responsible for the knowledge/information disseminated during these meetings. Meeting content will be available for review through established mechanisms such as published minutes, e-mail messages, or other forms of communication.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. Independent Entity: VA Health Care System, St. Cloud, MN, is an independent entity, granting privileges to the Organized medical staff through the recommendation of the PSB with endorsement of the MEB and approval of the Health Care System Director as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Appointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Appointments for contracted staff do not exceed the date of the contract expiration. Organized

Medical Staff must practice within their delineated privileges. Mid-Level and Associated Health Practitioners must practice within their delineated scope of practice.

2. Credentials Review: All Organized Medical Staff members as defined in these Bylaws who hold clinical privileges 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.

3. Deployment/Activation Status:
   a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges/scope of practice 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 PSB for recommendation to restore privileges/scope of practice to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and PSB to put an FPPE in place to support current competence. PSB recommendations are forwarded to MEB. MEB endorses recommendations to the Director who has final approval for restoring privileges/scope of practice to active and current status.
   c. In those instances where the privileges/scope of practice 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/scope of practice held prior to the call to active duty and whether a request for modification of these privileges/scope of practice should be initiated, on a short-term basis. These practitioners 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 (FPPE):

   a. The initial focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege/scope of practice-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege/scope element at the organization. This occurs with a new Practitioner or an existing Practitioner who request a new privilege/scope element. 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/scope element
      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 (OPPE):

a. The on-going monitoring of privileged practitioners and practitioners practicing autonomously within a scope of practice 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/scopes of practice make the on-going monitoring of privileges/scopes 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.) Relevant practitioner data is reviewed ongoing at the Service Line level as available and twice yearly by PSB Committees. Consideration may be given to the number and type of procedures, and may consider high risk or high volume for an adjustment to increase the frequency of review cycle.

(1) 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 practitioner-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.

ii.) 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/scope of practice, but the service chief must clearly document the basis for the recommendation of renewal of privileges/scope of practice.

(1) The PSB 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/issuance of scope of practice to the MEB. This deliberation must be clearly documented in the minutes.

(2) The MEB Credentialing Committee will review all PSB considerations of information available prior to endorsing recommendations to the Director. This deliberation must be clearly documented in the minutes.

iii.) 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/scope of practice and document this consideration.

Section 7.02 Application Procedures

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete application in accordance with VHA Handbook 1100.19. Medical Staff appointment does not equate to HR employment.

   a. The applicant must submit credentialing information through VetPro as required by VHA guidelines. 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.

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

      i.) Active, Current, Full, and Unrestricted License: 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.) Certification of Basic Life Support (BLS) or BLS/Advanced Cardiac Life Support (ACLS) from an approved program such as American Heart Association.

      ix.) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges/scope of practice 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.

   c. 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.

   d. 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/scope of practice proposed 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 Facility Director may require additional information.

   e. 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.

iv.) Scope of practice held and any disciplinary actions taken or pending against the scope of practice, including suspension, revocation, limitations, or voluntary surrender.

f. 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.

g. 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.

h. 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.

i. Loss of Privileges/Autonomous practice rights: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges, or voluntary or involuntary limitation, reduction or loss of autonomous practice rights at another health care facility.

j. 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.

k. 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/scope of practice 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 Organized Medical Staff and those Practitioners with authorized autonomous practice through a scope of practice.

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. It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the Practitioner, requesting all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the Practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint. Questions concerning applicants, who may qualify for appointment under the Rehabilitation Act of 1974, need to be referred to Regional Counsel.

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 practitioners must submit credentialing information into VetPro as required by VHA policy.

Section 7.03 Process and Terms of Appointment

1. Service Line Medical Director Recommendation: The assigned Service Line Medical Director 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/scope of practice are met.

2. NPDB-HIPDB Query Results:, The Applicant's file must be submitted to the VISN Chief Medical Officer (CMO) for review and action recommendation if the NPDB-HIPDB query indicates for or on behalf of the Applicant any of the following:

   a. Three or more medical malpractice payments

   b. A single medical malpractice payment of $550,000 or more

   c. Two medical malpractice payments totaling $1,000,000 or more

3. VISN CMO Review: Review by the VISN CMO is required for applicants seeking initial appointment who have had any licensure actions or may have any pending licensure actions and those applicants receiving NPDB-HIPDB query result indicators. The VISN CMO review is completed prior to presentation to the MEB. The VISN CMO review will be documented on the Service Line Medical Director's Approval screen in VetPro as an additional entry. The applicant's file is submitted to the VISN CMO to:

   a. Determine if the appointment and privileging process should continue

   b. Ensure an appropriate review is completed in the credentialing process

   c. Assure that all circumstances, including the Applicant's explanation are weighed

   d. Determine if the appointment is appropriate

   e. Consult with Regional Counsel as needed

4. PSB/MEB Recommendation: PSB recommends Medical Staff appointment to the MEB based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges/scope of practice are met. MEB reviews all evidence and endorses PSB recommendations to the Health Care System Director.

5. 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 Line Medical Director and PSB/MEB.

6. 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/scope of practice has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges/scope of practice 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. 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 practitioner requesting privileges or scope of practice. Maintenance of the C&P file is the responsibility of the Credentialing Coordinator with oversight 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 or approved scope of practice, at the time of request for additional privileges or change in the scope of practice, or in case of a “for-cause” event requiring a focused review. Procedures are outlined in HCSM CD 11-45.

5. Ongoing Professional Practice Evaluation: Ongoing Professional Practice Evaluation (OPPE) shall be in force for all Medical Staff members practicing under defined clinical privileges or under a Scope of Practice agreement. Procedures and performance elements are outlined in HCSM CD 11-45.

Section 7.05 Local/VISN-Level Compensation Panels

Local or VISN-level Compensation Panels, as appropriate, 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/SCOPE OF PRACTICE

Section 8.01 General Provisions

1. Clinical privileges are granted to only physicians, dentists, podiatrists, and optometrists. APRN, PA, and other Associated Health Professionals may practice autonomously under a Scope of Practice. _APRN, PA, and other Associated Health Professionals are monitored for clinical competency and quality through the medical staff processes, however adverse actions are handled in accordance with VHA Handbook 5021.

2. Clinical privileges are granted and scopes of practice issued for a period of no more than 2 years for all medical staff. Privileges or scopes of practice for contract staff are granted for the duration of the contract period or two years, whichever is less.

3. Reappraisal of privileges/scope of practice is required of each Medical Staff member who has clinical privileges or practices under a Scope of Practice. Reappraisal is initiated by the Practitioner's Service Line Medical Director at the time of a request by the Practitioner for new privileges, changes in a scope of practice or renewal of current clinical privileges/scope of practice.

    a. Although the reappraisal process occurs at least every two years, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.

    b. Reappraisal requires documentation of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements. Evidence of formal documentation may be requested of the practitioner.

    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 PSB/MEB. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges/scope of practice (VHA Handbook 1100.19).

4. A Practitioner may request modification or accretion of existing clinical privileges/scope of practice by submitting a formal request for the desired change(s) with full documentation to support the change to the Service Line Medical Director.

5. 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 and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.

6. Requirements and processes for requesting and granting privileges are the same for all Practitioners who seek privileges/scope of practice regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.

7. Practitioners with clinical privileges/scope of practice are approved for and have clinical privileges/scope of practice in one clinical Service but may be granted clinical privileges/scope of practice in other clinical Services. Clinical privileges granted/scopes of practice approved 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/scopes of practice cross to a different designated service, all Service Line Medical Directors must recommend the practice.

8. Exercise of clinical privileges/scope of practice within any Service is subject to the rules of that Service and to the authority of that Service Line Medical Director.

9. When certain clinical privileges/scopes of practice are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges/scope of practice specifically tied to the faculty appointment.

10. Telemedicine: All Medical Staff members who are responsible for the care, treatment, and services of patients via telemedicine link are subject to the credentialing and privileging/scope of practice process as for any on-site medical staff member in accordance with VHA Handbook 1100.19, Credentialing and Privileging.

a. The Medical Staff and/or MEB makes recommendations and approves the clinical services to be offered via telemedicine.

b. Clinical services to be offered are consistent with commonly accepted quality standards.

c. Telemedicine services may be provided by practitioners not associated with or employed by the St. Cloud VA. In such cases there shall be a signed Memorandum of Understanding (MOU) and Telehealth Service Agreement (TSA) between the providing and receiving facilities. The practitioner shall be credentialed and privileged at the providing facility and the practitioner's practice is limited to the privileges granted by the providing facility. Credentialing, privileging and quality monitoring data of the practitioner shall be shared between the providing and receiving facilities as appropriate.

11. 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.

a. **Teleconsultation Only Appointment:** A practitioner only providing teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located when providing teleconsultation services.

i) The practitioner's credentials must be shared with the receiving (St. Cloud) site, via shared access to VetPro.

ii) With the exception of a NPDB/HIPDB query, the practitioner does not have to be appointed or credentialed and privileged at the site where the patient is located (St Cloud).

iii) A copy of the practitioner's privileges will be made available to the site where the patient is physically located (St. Cloud).

Section 8.02 Process and Requirements for Requesting Clinical Privileges/Scope of Practice

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges/scope of practice 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/scope of practice.

2. Requests in Writing: All requests for clinical privileges/scope of practice must be made in writing by the Practitioner and include a statement of the specific privileges/scope elements being requested in a Memorandum format approved by the Medical Staff.

3. Credentialing Application: The Practitioner applying for initial clinical privileges/scope of practice must submit a complete application for privileges/scope of practice that includes:

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

b. Application for clinical privileges/scope of practice as outlined in this Article.

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

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

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/scope of practice at any other hospital within 15 days of the adverse action.

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

i. Evidence of successful completion of an approved BLS or ACLS program, as appropriate for the applicant's position, which meets the criteria of the American Heart Association.

4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges/issuance of a scope of practice, 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/scope of practice, the Practitioner must have specific, approved clinical privileges/scope of practice and acknowledge that he/she has received a copy of Sedation and Analgesia by Non-Anesthesia Providers policy (HCSM CD 11-17) and agree to the guidelines outlined in the policy.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges/Scope of Practice

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

a. An application for clinical privileges/scope of practice 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/scope of practice will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges/scope of practice elements with the appropriate Service Line Medical Director prior to formal submission of privilege/scope of practice 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/scope of practice. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEB.

d. Documentation of continuing medical education related to area and scope of clinical privileges/scope of practice elements, (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:

i) Sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society

ii) Voluntary or involuntary relinquishment of licensure or registration

iii) Malpractice claims, suits or settlements (e.g. final judgment or settlements)

iv) Reduction or loss of privileges/reduction or loss of scope of practice 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/scope of practice requested.

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

i. Certification of Basic Life Support (BLS) or BLS/Advanced Cardiac Life Support (ACLS) from an approved program such as American Heart Association. Exceptions to this certification are outlined in HCSM CD 11-27 Code Blue.

2. Verification: Before granting subsequent clinical privileges/scope of practice, the Credentialing and Privileging 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/scope of practice requested.

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges/Scope of Practice

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges/scope of practice 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 Line Medical Director. 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. practitioner 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/scope of practice requires the recommendation of the PSB to the MEB who endorses the recommendation to the Director for approval.

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

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.

2. The Service Line Medical Director where the applicant is requesting clinical privileges/scope of practice is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges/scope of practice.

    a. Recommendations for initial, renewal or modification of privileges/scope of practice are based on a determination that applicant meets criteria for appointment and clinical privileges/scope of practice 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/scope of practice 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. The MEB endorses PSB recommendations for granting clinical privileges/scope of practice to the Facility Director based on each applicant successfully meeting the requirements for clinical privileges/scope of practice as specified in these Bylaws.

4. Clinical privileges/scope of practice are acted upon by the Director within 30 calendar days of receipt of the MEB endorsement of PSB recommendation to appoint. The Director's action must be verified with an original signature.

5. Originals of approved clinical privileges/scope of practice are placed in the individual Practitioner's Credentialing and Privileging File. A Copy of approved privileges/scope of practice are given to the Practitioner and are readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.

6. APRN and PA practitioners practicing under an approved Scope of Practice and granted prescriptive authority are subject to the afore-mentioned Medical staff processes.

7. Changes made to an APRN and PA practitioner's request for a scope of practice during the review and approval process are documented including communication with the practitioner and the reason for the changes. Removal or non-renewal of a requested scope of practice may require other adverse employment actions in accordance with VHA Handbook 5021 and may require reporting to the State Licensing Board.

8. Changes made to a practitioner's request for clinical privileges during the review and approval process are documented including communication with the practitioner and the reason for the changes. Removal or non-renewal of requested privileges may require appropriate due process proceedings and may require reporting to the National Practitioner Data Bank.

Section 8.06 Exceptions

1. Temporary Privileges/scopes of Practice for Urgent Patient Care Needs: Temporary clinical privileges/scopes of practice 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 60 calendar days, by the Director or Acting Director on the recommendation of the Chief of Staff.

   a. Temporary privileges/scopes of practice 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/scope of practice 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/scope of practice.

      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/scope of practice being granted and credentialing completed.

2. Expedited Process:

   a. The Practitioner must submit a completed application through VetPro.

   b. The Facility:

      i) Verifies education and training;

      ii) Verifies one active, current, unrestricted license from a State, Territory, or Commonwealth of the United States or the District of Columbia;

      iii) Receives confirmation on the declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges/scope of practice being sought;

      iv) Queries licensure history through the Federation of State Medical Boards (FSMB) Physician Data Center and receives a response with no report documented;

      v) Receives confirmation from two peer references who are knowledgeable of and confirm the practitioner's competence, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges/scope of practice, or who would have reason to know the individual's professional qualifications.

      vi) Verifies current comparable privileges/scope of practice held in another institution; and

      vii) Receives a response from NPDB-HIPDB PDS registration with no match.

      viii) Verifies that there are no current or previously successful challenges to licensure.

      ix) Verifies that there is no history of involuntary termination of medical staff membership at another organization.

      x) Verifies that there is no history of voluntary limitation, reduction, denial, or loss of clinical privileges/scope of practice.

xi) Verifies that there is no history of final judgments adverse to the applicant in a professional liability action.

c. A delegated subcommittee of the MEB, consisting of at least two voting members of the full committee, recommends appointment to the medical staff.

d. The recommendation by the delegated subcommittee of the MEB must be acted upon by the Facility Director.

e. Full credentialing must be completed within 60 calendar days of the date of the Director's signature and presented to the MEB for ratification.

3. 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/scope of practice, 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.

4. Disaster Privileges/Scope of Practice: Disaster Privileges/Scope of Practice may be granted by the Health Care System Director or Chief of Staff or their designee(s) in circumstances of disaster(s) in which the emergency management plan has been activated, and it is determined that it is not possible to handle the influx of patients with the existing Practitioners. The option to grant disaster privileges/scope of practice is made on a case-by-case basis in accordance with the needs of the organization and needs of the patients.

a. The Director or Chief of Staff or the designee granting disaster privileges/scope of practice is responsible to initiate actions for completion of verification, assigning facility physician oversight, and evaluation of performance at the end of 72 hours or as soon as possible in extraordinary circumstances.

b. Practitioners granted disaster privileges/scope of practice will be distinguished from others currently appointed at the facility by wearing a unique identification badge.

c. An assigned, appropriately credentialed and privileged physician oversees the professional practice of each volunteer, Licensed Independent Practitioner, Mid-Level Practitioner, and Associated Health Practitioner. The assigned physician will direct clinical activities of practitioners granted disaster privileges/scope of practice and will identify these practitioners to other staff supporting or performing clinical care to affected patients.

d. Verification processes for granting disaster privileges/scope of practice will, at a minimum, include a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) and at least one of the following:

i) Evidence of a current license (pocket card sufficient) to practice.

ii) And one of the following:

(1) A current medical facility photo ID card.

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

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

e. The quality of the care and service rendered by each volunteer Practitioner with Disaster Privileges/scope of practice must be evaluated at the end of 72 hours and a determination made as to whether or not the Practitioner will be permitted to continue providing services.

i) This evaluation may be done by the assigned oversight physician or the Chief of Staff/designee

ii) The evaluation will be reported to the Director or Chief of Staff or their designee

iii) The Director or Chief of Staff or designee determines if the Practitioner will be permitted to continue providing services.

f. Primary source verification of licensure must occur as soon as the disaster is under control or within 72 hours from the time the practitioner presents to the facility, whichever comes first. If primary source verification of a practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the facility documents the reason(s) it could not be performed within 72 hours of the practitioner's arrival, evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment, and services, and evidence of the hospital's attempt to perform primary source verification as soon as possible.

g. The documentation will serve as credentials verification for a period not to exceed ten (10) calendar days or length of the disaster, whichever is shorter. Primary source verification of licensure will be obtained within seventy-two (72) hours after the disaster is under control, or as soon as possible in extraordinary circumstances.

h. In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the 10 calendar days or the length of the declared disaster, whichever is shorter, noted in paragraph g above, the Practitioner must be converted to Temporary Privileges/scope of practice in accordance with VHA Handbook 1100.19, Credentialing and Privileging, for a period not to exceed 60 working days.

5. Inactivation of Privileges/Scope of Practice: The inactivation of privileges/scope of practice 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. Extended time period is individually determined based on an evaluation by the Service Line Medical Director. The Service Line Medical Director will evaluate the Practitioner considering the length of the extended period, likelihood of return to active practice, and any anticipated changes in the Practitioner's knowledge, skills, or competency during the absence. If the extended period is planned in advance, Service Line Medical Directors may discuss inactivation status with the involved Practitioner prior to the planned absence. After evaluation, the Service Line Medical Director will present recommendations to PSB for inactivation of privileges/scope of practice. PSB recommendations are forwarded to MEB for endorsement to the Health Care System Director.

a. When the Practitioner returns to the Facility, credentialing and privileging/scope of practice 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/scope of practice may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges/scope of practice where such action(s) is warranted.

b. Within 7 calendar days of the date inactivation of privileges/scope of practice, including separation from the medical staff, the Chief of Staff oversees the process to ensure information is documented in the Practitioner's permanent credentialing and privileging record indicating the Practitioner met generally accepted standard s of clinical practice and there is no reasonable concern for the safety of patients, in accordance with VHA Handbook 1100.18.

6. Deployment and Activation Privilege/Scope of Practice Status: In those instances where a Practitioner is called to active duty, the Practitioner's privileges/scope of practice are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges/scope of practice in this new status. If at all possible, the process described below for returning privileges/scope of practice 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/scope of practice to an Active Status, and the Service Chief's recommendation are presented to the PSB for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the PSB is documented and forwarded to the MEB. MEB endorses the recommendation directly to the Director for approval of restoring the Practitioner's privileges/scope of practice to Current and Active Status from Deployment and/or Activation Status.

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

f. In those instances where the privileges/scope of practice 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/scope of practice 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/scope of practice 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/scope of practice 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 not to exceed 60 calendar days.

ARTICLE IX INVESTIGATION AND ACTION

The procedures outlined below are applicable only to Physicians, Dentists, Podiatrists and Optometrists with delineated clinical privileges. When the behaviors, activities and/or professional conduct of any Practitioner practicing autonomously within a defined scope of practice are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards expected, or to represent Professional misconduct or clinical incompetence, grievance procedures as outlined in VHA Handbook 5021 shall be followed.

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, Behavior or Behaviors That Undermine a Culture of Safety, 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 Facility Director.

a. 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.

b. 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. When the person under review, is an employee then the processes must also follow VA Directive 5021 - Management of Employees (Appendix A pages 2-9).

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.

a. The fact-finding process will be completed within 30 days or there will be documentation as to why that was not possible.

b. 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, Behavior or Behaviors That Undermine a Culture of Safety, 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 PSB.

3. Review by PSB:

a. The PSB investigates the charges and makes a report of the investigation to the MEB within 14 days after the PSB has been convened to consider the request for corrective action.

b. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the PSB to discuss, explain or refute the charges against him/her.

c. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto.

d. An investigation by the PSB is an administrative matter and not an adversarial Hearing.

e. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations reported to the MEB.

4. MEB Action:

a. Within 14 days after receipt of a report from the PSB, the MEB acts upon the request.

b. If the action being considered by the MEB 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 MEB prior to the committee's action on such request.

c. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto.

d. A record of such proceeding is made by the MEB.

e. The MEB 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.

f. Any recommendation by the MEB 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.

g. Reduction of privileges may include, but are not limited to:

i) Functioning under supervision

ii) Restricting performance of specific procedures or prescribing and/or dispensing controlled substances.

iii) Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.

h. 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 MEB 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.

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

b. The Chief of Staff convenes the PSB to investigate the matter and make a report thereof to the MEB within fourteen (14) days after the effective date of the Automatic Suspension.

c. Immediately upon the occurrence of an Automatic Suspension, the Service 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 PSB 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:

e. The appointment of an ad hoc investigation committee;

f. The conduct of an investigation into any matter;

g. 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;

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

i. 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;

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

k. Corrective counseling;

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

m. 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. 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

The procedures outlined below are applicable only to Physicians, Dentists, Podiatrists and Optometrists with delineated clinical privileges. When the behaviors, activities and/or professional conduct of any Practitioner practicing autonomously within a defined scope of practice are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards expected, or to represent Professional misconduct or clinical incompetence, grievance procedures as outlined in VHA Handbook 5021 shall be followed.

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

   a. 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.

   b. 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.

   c. 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.

b. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.

c. 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.

iv) 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 <u>not</u> 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. The decision of the VISN Director is not subject to further appeal.

5. <u>The hearing panel chair shall do the following:</u>

a. 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.

b. 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.

c. Maintain decorum throughout the hearing.

d. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.

e. 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.

f. Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.

g. Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

6. <u>Practitioner Rights:</u>

a. 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.

b. 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.

c. 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.

d. The Practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.

e. 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.

f. 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.

g. The review panel hearing described above 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.

h. 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.

7. Revocation of Privileges:

a. 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.

b. 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 the MEB 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.

8. Reporting to the National Practitioner Data Bank:

a. 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.

b. 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.

c. 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.

d. 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.

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

9. 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.

10. 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 of the MEB 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/ revised and approved by the Organized Medical Staff as a whole at least every two years. Acceptance and adoption of the Bylaws is by majority vote during a regular scheduled Medical Staff meeting in which there is a quorum and submitted to the Director for approval.

2. As necessary, revisions are made to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. The MEB may adopt amendments to the Rules and Regulations that are deemed necessary for legal or regulatory compliance. After adoption, these amendments to the Rules and Regulations will be communicated back to the Organized Medical Staff for review through publication of MEB minutes, presentation at Medical Staff meetings or presentation at Service Line Medical Staff meetings. If there is no conflict, the adoption of the amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.05 will be followed.

3. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff.

4. Minor revisions and recommended changes can be endorsed by MEB for Health Care System Director's approval. MEB will determine those items constituting a minor revision.

5. Written text of proposed significant changes is to be provided to Medical Staff members. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.

6. All changes to the Bylaws require action by both the Organized Medical Staff, as a whole or through MEB, and Facility Director. Neither may unilaterally amend the Bylaws.

7. 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 MEB. If the MEB proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the medical staff. When the MEB adopts a policy or amendment thereto, it must communicate this to the medical staff.

RECOMMENDED

/s/ — 6/27/13

S.M. Markstrom, M.D.
Chief of Staff

Date

APPROVED

/s/ — 8/13/13

Barry I. Bahl
Director

Date

3. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff.

4. Minor revisions and recommended changes can be endorsed by MEB for Health Care System Director's approval. MEB will determine those items constituting a minor revision.

5. Written text of proposed significant changes is to be provided to Medical Staff members. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.

6. All changes to the Bylaws require action by both the Organized Medical Staff, as a whole or through MEB, and Facility Director. Neither may unilaterally amend the Bylaws.

7. 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 MEB. If the MEB proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the medical staff. When the MEB adopts a policy or amendment thereto, it must communicate this to the medical staff.

RECOMMENDED

S.M. Markstrom, M.D.
Chief of Staff

6/27/13.
Date

APPROVED

Barry I. Bahl
Director

8/13/13
Date

MEDICAL STAFF RULES

I. GENERAL

A. The Rules relate to role and/or responsibility of members of the Medical Staff and individuals with clinical privileges/scopes of practice 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 generally meets monthly, but shall hold meetings at least annually.

D. The MEB serves as the executive committee of the Medical Staff and between Medical Staff 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 Medical Staff 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. Minutes from clinical Service meetings will be submitted to the MEB in a timely manner.

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

II. PATIENT RIGHTS

A. Patient's Rights and Responsibilities: VA Health Care System, St. Cloud, Medical Staff shall ensure that the patient receives prompt and appropriate treatment. It is the responsibility of each employee to observe the patient's rights with an attitude of service and compassion. This Organization supports the rights of each patient including each of the following: (Reference HCSM CD 00-28, Patient Rights; HCSM CD 11-37, Informed Consent; and HCSM CD 11-26, Advance Directives, Withholding or Withdrawing of Life Sustaining Treatment).

1. Reasonable response to requests and need for service within capacity, mission, laws and regulations.
2. Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
3. Collaboration with the physician in matters regarding personal health care.
4. Pain management including assessment, treatment and education.
5. Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.
6. Formulation of advance directives and appointment of surrogate to make health care decisions
7. 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.
8. Access to information about patient rights, handling of patient complaints.

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

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

11. Personal privacy and confidentiality of information.

12. 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.

13. Authority of Chief of Staff, or designee, 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.

14. Foregoing or withdrawing life-sustaining treatment including resuscitation.

15. 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: Medical Staff actions will be in accordance with VHA Handbook 1004.1- Informed Consent and shall reflect adherence to the following:

1. 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.

2. 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

3. 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.

4. 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.

5. 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.

6. 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 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 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 the Integrated Ethics Committee (HCSM CD 11-09).

III. RESPONSIBILITY FOR CARE

A. Conduct of Care

1. Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff. It is the responsibility, as stated in the Bylaws, for all Medical Staff to manage the patient's general medical condition within the scope of practice/privileges granted by the Health Care System Director. Medical Assessment of the patient shall include as appropriate:

   a. Medical assessment, including:
      (1) Chief complaint
      (2) Details of present illness
      (3) Relevant past, social and family history
      (4) Inventory by body system, including pain assessment
      (5) Summary of the patient’s psychological needs
      (6) Report of relevant physical examinations
      (7) Statement on the conclusions or impressions drawn from the admission history and physical examination
      (8) Statement on the course of action planned for this episode of care and its periodic review
      (9) Clinical observations, including the results of therapy

2. All patients shall be attended by members of the Medical Staff .

3. 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.

4. Each Medical Staff member has the right not to participate in care delivery if the basis is related to the caregiver's personal cultural values, ethics, and religious beliefs. The staff member's Service Line Medical Director must be notified immediately of the situation to arrange for care delivery to the patient to avoid any disruption of the care being provided. Cases of care delivery transfer based on ethical, cultural, and religious beliefs will be reviewed.

5. 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 physician practitioner as defined in facility policy HCSM CD 11-76 Inter/Intra Facility Transfers.

B. Emergency Services

1. This health care facility can provide emergency treatment on a very limited basis. The Health Care System is not equipped or staffed for full emergency care.

2. Injured persons presenting themselves at this Health Care System for urgent/emergent care, whether or not a Veteran, will receive adequate assessment and advice or initial treatment by a qualified member of the medical staff.

3. Persons in need of emergency treatment will be referred to the St. Cloud Community Hospital, or VAMC, Minneapolis, MN, or appropriate medical facility, as clinically appropriate.

4. Patients requiring emergency medical or surgical treatment not available at this hospital will be stabilized and then transferred to a local hospital or other appropriate facility.

   a. Transfer to the community hospital shall be authorized by the Chief of Staff or Service Line Medical Director or their designee.

   b. A positive acceptance must be given by the receiving facility or physician and be documented in the medical record.

   c. Any pertinent medical data will be sent with the patient when transferred.

   d. Under no circumstances will emergency services be denied based on ability to pay or eligibility.

5. During regular working hours, a qualified member of the medical staff will assess and triage patients per service line policy to the most appropriate care setting. During non-regular hours, the Medical Officer of the Day (MOD) will assess and triage patients to the most appropriate care setting.

6. Rosters designating physician members on duty, or on call for medical, mental health or surgical coverage and consultation, are posted throughout the facility.

C. Surgery/Invasive Procedures

1. Surgery is limited to minor procedures, diagnostic invasive procedures, and those appropriate to be performed in an Ambulatory Surgery Center (ASC) at this Health Care System.

a. An appropriate assessment of the patient's condition must be completed before a surgical procedure may be performed, including evaluation findings, diagnosis(es), assessment of risk, treatment plan and/or procedure to be performed.

(1) For Outpatient Surgeries/Invasive Procedures requiring a comprehensive H&P: The SSC service line will arrange for the primary care provider or other qualified practitioner to perform and record the H&P. The H&P will include a statement about the chief complaint, procedure to be done, and a review of systems addressing each of the patient's active problems, focusing on the stability and optimization of each problem.

(2) For patients undergoing any procedure which will require only a local anesthetic and/or moderate sedation administered directly by the performing practitioner or given under his/her supervision, the performing practitioner can perform the H&P addressing the stability and optimization of medical problems and assign an ASA classification.

(3) All patients undergoing procedures requiring general anesthesia, regional anesthesia, or deep sedation will be seen by an Anesthesia practitioner prior to the procedure at which time an H&P exam will be performed and an ASA classification designated.

b. Prior to Surgery: An H&P must be completed within 30 days prior to surgery and available in the medical record prior to the surgery/invasive procedure. On the day of surgery, prior to the procedure, an interval note is required to be in the record indicating:

(1) The H&P is still accurate.

(2) An appropriate assessment was completed prior to surgery confirming that the necessity for the procedure is still present.

(3) The patient's condition has not changed since the H&P was originally completed, or any changes are documented.

(4) An exception to the interval note requirement is allowed if the H&P is completed on the day of surgery.

c. A surgical procedure will be performed only with the consent of the patient or his/her legal representative. In the case of emergency treatment, the practitioner may proceed to provide the necessary medical care without obtaining consent when the following three conditions exist:

(1) The patient is unable to consent to a procedure/treatment;

(2) Immediate medical care is necessary to preserve the life or prevent serious impairment of the health of the patient; and,

(3) The treatment practitioner determines that obtaining consent from the patient's representative would result in a delay that would increase the hazards to the life or health of the patient or others. In such case, the patient's consent is implied by law. A dated and signed progress note documenting the imminent danger and the decision to proceed must be written by the practitioner. If time permits, reasonable attempts should be made to contact the patient's representative to obtain consent. If time does not permit, contact should be made as soon as possible. The signature of the Chief of Staff is required on the SF 522 in cases where diagnostic or therapeutic efforts are based upon an implied consent.

2. All pathology specimens are sent to lab except specimens approved for exemption from pathological examination (see HCSM CD113-06 Submission of tissue samples to Pathology). Practitioners are to be

knowledgeable about specimen submissions including specimens that are not routinely submitted and specimens that need to be submitted for gross examination only.

D. Admissions

1. Admission to the Medical Center or is determined by a member of the Medical Staff in consultation with the service of assignment, when possible. APRNs and PAs can admit to their service areas within their Scope of Practice privileges. Except in an emergency, patients admitted to the Medical Center will have a provisional diagnosis, or appropriate problem identified and entered into the medical record. In such instances that the provisional diagnosis cannot be entered into the medical record prior to admission, it will be entered as soon as possible. Patients will be attended to by a designated member of the medical staff and assigned to the service or section to which the patient is admitted.

2. History and Physical (H&P) Examination:

   a. An H&P pertinent to an acute care admission will be done in the medical record within 24 hours of admission. If an H&P examination has been performed within 30 days prior to admission, a copy of this report may be used provided any changes in patient condition that may have occurred are recorded at the time of admission and prior to surgery or a procedure requiring anesthesia services.

   b. Dentists, podiatrists and optometrists admitting patients for dental, podiatric or eye care/procedures are responsible for the portion of the patient's care applicable to their area of specialty and to complete a pertinent H&P exam upon admission. The receiving admission unit will designate a qualified medical staff member to complete unit admission orders and conduct the remainder of the patient's H&P medical exam. The admitting unit practitioner caring for the patient on his/her inpatient service and the dentist/podiatrist/optometrist will cooperate in the over-all care of the patient.

   c. Medical history and physical examinations will include minimum requirements of the chief complaint, a brief history of present illness or problems; examination of the affective body area or organ system, and other symptomatic or related organ system as appropriate.

   d. Residents admitted to any Community Living Center (CLC) unit will have an H&P completed and signed within 72 hours of admission. All practitioner visits will be documented.

   e. Patients admitted to short stay status will have an H&P completed within 24 hours of admission.

   f. Residents admitted to the Mental Health Rehabilitation and Recovery Treatment Program (MHRRTP) will have an H&P completed and signed within 7 days of admission.

3. Inpatient, Community Living Center and Residential Visits and Documentation

   a. All acute unit inpatient practitioner visits will be documented and a Plan of Care initiated/updated within 8 hours of admission, with an interdisciplinary review within three days.

   b. Assigned CLC practitioners will complete at least one patient visit within the first 30 days of admission.

   c. Practitioners assigned to short stay status patients will complete visits daily and document all visits, per policy.

   d. MHRRTP: The Plan of Care is initiated by the provider upon admission to the appropriate residential care setting, completed by the assigned primary case manager within 7 days of

admission and reviewed by the Interdisciplinary team. The Integrated summary is to be completed within 7 days of admission and pertinent updates made to the plan of care as indicated.

e. A member of the Medical Staff, who has been granted privileges/issued a scope of practice by the St. Cloud VAMC, shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to the family of the patient as appropriate. Whenever these responsibilities are transferred to another staff member, an order and accompanying progress note will be entered into the patient record to reflect transfer of responsibility and the status of the patient at the time of transfer. The practitioner assuming responsibility for the patient shall also document his/her acceptance of the responsibility for the patient's care.

f. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or appropriate problem identification has been stated on the medical record.

4. Procedures

a. Patients are assigned to the care of a member of the medical staff who is responsible for:

(1) Medical care and treatment

(2) Prompt completion and accuracy of the medical record

(3) Special instructions including diet and activity

(4) Transmitting reports on the condition of the patient to referring practitioner and family or the patient's next of kin

(5) Except in an emergency, not admitting until after admitting diagnosis is entered into the medical record

b. Diagnostic testing

(1) There are no pre-defined sets of standardized tests for admission. Practitioners are to request tests as clinically appropriate to assess conditions and guide appropriate treatment. Laboratory and Radiology Service is available on an on-call basis during weekends and after hours.

(2) Patient consent for testing and treatment may be given verbally by the patient or patient health authority and will be documented by the practitioner in the medical record as appropriate.

(3) Candidates for admission to the Ventilator-Dependent Unit, Community Living Centers (CLC), and Mental Health Residential Rehabilitation Treatment (MHRRTP) will be screened by utilizing criteria approved by the appropriate Service Line Medical Director. All candidates will be evaluated after arrival in a timely manner by a medical staff member for admission to the appropriate level of care, as per service line policy.

(4) It is expected that members of the medical staff will adhere to the provisions of the Test Results Notification HCSM (CD11-10).

E. Consultations:

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

   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.

   d. When requested by the patient or his/her family

2. 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.

3. Essentials of a Consultation: A satisfactory consultation includes examination of the patient and/or 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.

4. Responsibility for Requesting Consultations: The patient's practitioner, through the Service Line Medical Director, shall make certain that members of the staff do not fail in the matter of providing consultation as needed.

5. 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. Transfers to another facility

1. Arbitrary transfers are prohibited when the Health Care System has the means to provide adequate care to Veterans with established eligibility or for patients requiring humanitarian or emergency treatment. Transfers follow procedures as outlined in CD 11-76 Inter/Intra Facility Transfers.

2. Patients requiring emergency care not available at this facility will be stabilized within the scope of this facility and then transferred to a local hospital or other appropriate facility. EMTALA rules will be considered as per the following points:

   a. APRN/PA practitioners recommending transfer to a non-VA facility will gain concurrence by a collaborating/supervising physician.

   b. A positive acceptance must be given by the receiving facility or physician and be documented in the medical record. Transferring practitioner will determine mode of transport.

   c. Patient informed consent must be obtained prior to transfer.

   d. Practitioner will document reason for transfer, assessment of physical/psychosocial stability, or risk/benefit if unstable, and summary of care provided at the facility.

   e. Pertinent medical data will be transferred with the patient and documented in the medical record.

3. Responsibility for the patient during transfer lies with the referring institution until the patient is physically accepted at the receiving facility.

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

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

2. Discharge planning is documented in the medical record.

3. Discharge Planning will be conducted at the ward level. Criteria for discharge are determined by the Multidisciplinary Treatment Team and include:

   a. Availability of appropriate services to meet patient needs

   b. Early discussion with family members, next of kin, or caregivers concerning patient needs

   c. Patient and support persons educational needs

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

H. Discharge

1. Patients shall be discharged from the Facility only upon the written order of the responsible medical staff member 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 completed (signed) summary must be available for viewing in CPRS prior to discharge or within 24 hours of death or irregular discharge for inpatients. The summary must be completed with 72 hours for Community Living Centers and Mental Health Residential Rehabilitation Treatment.*

2. 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.

I. Autopsy: All autopsies are conducted in accordance with guidelines as outlined in *VHA Handbook 1106.01*

1. Autopsy services are provided by Minneapolis VA Health Care System. The availability of these services will be made known to the family of each decedent and the Medical 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.
2. 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 17-170. 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.
3. Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.170, and VHA Handbook 1106.01 Autopsy Services (which includes Criteria for assignment to medico-legal status).
4. Autopsy Rates. Autopsies are encouraged as per VHA policy.
5. 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 38 CFR 17.170, VHA Handbook 1106.01 and HCSM CD 11-14, Notification of Next of Kin of Seriously Ill, Deaths, and Autopsy Request. 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.

6. 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.

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

J. Organ/Tissue Donation**:** Organ and tissue donation will occur following the procedures outlined in the "Organ, Tissue, and Eye Donor Policy" Health Care System Memorandum (HCSM CD11-03).

K. Restraint and Seclusion: As this facility strives to maintain a restraint-free environment, the use of Restraint and Seclusion is specifically outlined in HCSM CD11-56.

1. The use of restraints and/or seclusion is appropriate only:

   a. When the patient is in danger of injuring self, or

   b. When the patient is in danger of injuring others, or

   c. When the patient is in danger of seriously disrupting the therapeutic environment, and

   d. When less restrictive interventions have been unsuccessful or deemed inadequate or inappropriate.

2. Restraint or seclusion use is ordered by a clinically privileged member of the Medical Staff.

3. Written orders for restraints or seclusion are limited to

   a. Four (4) hours for adults with primary behavioral health needs

   b. One month for patients in CLC units

4. When emergency use is initiated for behavioral use, a clinically authorized practitioner is called within one hour. Continued use depends on the authorization of the practitioner.

5. After the patient has been placed in restraints and/or seclusion and has regained control, a registered nurse may remove the patient from restraints and/or seclusion. If within the next 60 minutes the patient again exhibits the same type of behavior, the patient may be returned to restraint and/or seclusion without obtaining a new order. Re-institution of restraints or seclusion is not to exceed the time limit as stated in the original order. If the patient has been out of restraints or seclusion in excess of 60 minutes, another practitioner order is necessary.

6. After the original order expires, the patient receives a face-to-face reassessment by a practitioner. The practitioner must write a new order if the restraint or seclusion is to be continued.

7. For patients with primary behavioral health needs, a registered nurse may perform the reassessment and make a decision to continue the original order for an additional four (4) hours up to a maximum of 24 hours.

8. The use of PRN orders for restraints/seclusion is prohibited.

L. Protective Security

1. May be required in the care of combative or emotionally disturbed patient.

2. Emergency Code Green: Anytime a practitioner is confronted with a combative or emotionally disturbed patient, utilization of nursing staff and/or Police and Security Service may be accessed. In an emergency situation, utilize Code Green, Ext. 6213. Procedures are followed as outlined in HCSM CD 00-38 Code Green and Crisis Response.

3. Confused patient.

   a. Inpatients: Treatment teams may establish and grant privileges based on the patient's condition or status.

   b. If Medical Staff or Associated health professionals encounter an outpatient who demonstrates confusion as displayed by their behavior, it is the staff member's responsibility to provide safe intervention.

   c. Incident Reporting. An incident report (VHA Form 10-161) will be initiated without delay when a patient is involved in an incident that either has harmed, or has a potential of causing harm, to the individual or others.

M. Commitment Guidelines

1. All commitment procedures are outlined in HCSM CD 11-78 Civil Commitment Guidelines

2. Informal Admission: At the time of admission under informal status for mental illness, the Veteran is informed in writing of the right to leave the facility within 12 hours of written request. A Veteran admitted informally for substance abuse has the right to leave the medical center within 72 hours of written request, exclusive of Saturdays, Sundays, or holidays.

3. Placement Under Emergency 72-Hour Hold: Emergency 72-hour holds require a written statement from the physician.

4. Authorization of Emergency/Peace Officer's Hold on Admission: Admission to this medical center will be authorized only after Veteran is examined by a clinically authorized member of the Medical Staff to determine concurrence that the Veteran is "in imminent danger of causing injury to self or others if not immediately restrained."

5. AMA (Against Medical Advice) Discharge Requests: Patients requesting an AMA discharge will be interviewed by a practitioner who will assess the patient's mental condition. The documented assessment should include:

   a. The patient's recent behavior and current mental status.

   b. If patient is dangerous to self or others.

N. Emergency Code Blue: Cardiopulmonary Resuscitation (CPR) will be carried out on all patients at VAMC St. Cloud who develop cardiopulmonary arrest, unless documentation exists to the contrary such as DNAR - Advance Directives. The Code Blue may also be used in any circumstance when a rapid response team is needed to provide immediate medical assessment and treatment. The responding physician will be responsible for medical evaluation. Code response requirements are outlined in HCSM CD11-27, Code Blue.

IV. PHYSICIAN/OTHER PRACTITIONER ORDERS

A. General Requirements

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

2. Appropriate orders will be written at time of admission, discharge, inter-ward transfer, for periods of authorized absence from the Medical Center, and during the course of hospitalization as needed as well as with each outpatient visit as appropriate.

3. Verbal/Telephone orders are strongly discouraged except in emergency situations.

   a. Telephone orders will be accepted when the provider is not in the facility, cannot return to the facility in a timely manner and does not have remote access to CPRS.

   b. Telephone orders may be accepted by Registered Nurses, Pharmacists, PAs, APRNs etc. 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.

4. Do Not Attempt Resuscitation (DNAR) orders are written in accordance with VHA Handbook 1004.3 and must be written by a physician. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNAR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility of the assigned practitioner 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. Responsibilities and procedures are followed as outlined in CD 11-26, Advance Directives/Psychiatric Advance Directives/Withholding or Withdrawing Life-Sustaining Treatment.

B. Medication/Treatment Orders

1. Practitioner orders should be specific, identifying the medication requested, dosage, frequency, time limitations, duration of therapy, etc. Medication order stop dates continue up to 1:00 PM on the cited stop date. Unless a specified stop date is written, the effective order stop-date is 30 days from the date of the initial order.

2. PRN medication orders must identify condition of need and be time-limited.

3. Medication orders may be written for 365 days on the Ventilator Dependent Unit and the Community Living Centers.

4. Medical Staff members shall prescribe medications that have been approved for listing in the medication formulary. Non-formulary medications may be prescribed according to the process approved by the Medical Executive Board. As a mechanism to facilitate patient education, communication amongst health care providers, and to supplement informed consent, prescriptions will include the indication, symptom and/or condition for which the medication is being prescribed.

5. A medical staff member must write specific orders allowing a patient to take personal medication(s) brought into the Medical Center or for the patient to engage in self-administration of medications.

6. Registered dietitians may write orders for appropriate diet prescriptions and weight measure intervals. The orders may be implemented immediately, but must be countersigned by the practitioner within 2 workdays.

7. Medication orders entered by persons clinically authorized shall be limited to the specific terms as delineated by their signed practice agreement and within their designated scope of clinical practice. Highly specialized medications (e.g., chemotherapy agents, post-transplant agents, etc.) can only be prescribed with

VA specialist guidance and with necessary monitoring in accordance with VHA Directive 2009-038. Such communication must be documented in the health record.

8. APRNs and PAs may initiate or continue medication orders within his/her Scope of Practice. Exclusionary medications are written after consultation with the physician and are co-signed by a physician through progress note co-signature processes as cited below in Section V, paragraph B.

9. Clinically delegated functions by the MEB are performed by registered nurses guided by written protocols. Registered nurse protocols may be used at registered nurse' discretion to provide treatment for symptoms not covered by a current practitioner's order. Protocols will be in effect until 1:00 PM on the next administrative workday.

10. Prescribing of sedation is limited to those licensed practitioner's with approved clinical privileges/scope of practice.

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

12. Automatic Stop Orders:

    a. For medications, as follows:

        (i) All orders are subject to the Stop Date policy delineated in HCSM CD 11-108, Medication Prescribing/Ordering/Monitoring .

        (ii) No outpatient medication prescriptions will be honored beyond 365 days (one year).

    (2) Automatic stop dates are identified below. Medications cannot be administered beyond the stop date unless a new order is received.

Medication (Inpatient)	EC&R (CLC)	Mental Health
DEA Schedule II Narcotics	7 days, up to 30 days if provider specifies length of therapy	7 days
DEA Schedule III/IV/V non-narcotics		28 days
Antibiotics (IV)	84 days	N/A
Antibiotics (oral)	7 days	10 days
Stable Anticoagulation (review and rewrite	10 days	28 days
every 24 hours except for maintenance doses)	84 days	
Intravenous maintenance solutions		N/A
Large Volume IV's	24 hours	N/A
All other medications	24 hours	28 days
	365 days	

Medication (Outpatient)	Regular	Exceptional Circumstances
DEA Schedule II narcotics	30 days/no refill	60 days/no refill
DEA Schedule III-IV medications	30 days/5 refills	60 days/2 refills
All other medications	90 days/3 refills as clinically appropriate particularly with a stable dose, and overdose potential is low	With Medical Director Review

13. Ambulatory Care Medication Orders:

    a. All prescriptions must be entered electronically. Schedule II Controlled Substances will be entered electronically and will have a paper prescription form submitted to Pharmacy prior to dispensing to patient.

    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.

14. 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 practitioner, the existing orders remain valid.

C. Standardized Order Sets/Protocols: Standardized order sets are reviewed by the Medical staff and approved by the MEB at least every two years. Requests for review and changes are submitted to MEB by the involved Service Line Medical Director or ADPCS/NE. 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.

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:

1. Informed consent will be consistent with legal requirements and ethical standards, as described in Facility policy HCSM CD 11-37, Informed Consent.

2. 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: All tissues and objects except those defined in HCSM Path & Lab 113-06, HCSM CD113-06, and cited in Article III, Section C, Paragraph 2 of these Bylaws shall be sent to the Facility pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

G. Special Treatment Procedures:

1. Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and will be ordered, administered, and/or supervised only by those practitioners with approved and current privileges/scope of practice to do so.
2. Moderate sedation may be administered by a registered nurse, who has received competency-based education, in the presence of qualified medical staff with the appropriate privileges/scope of practice in accordance with the guidelines outlined in HCSM CD 11-17, Sedation by Non-Anesthesia Personnel (SNAP).

V. ROLE OF PHYSICIAN STAFF

A. Organized Medical Staff members are recognized by this facility as clinical leaders. As leaders, these members will provide guidance to other clinical staff through mentoring, sharing knowledge, promoting a vision of improved health care, supervising PAs and collaborating with APRNs to ensure that patients receive the highest quality care. All physicians are expected to provide collaborative consultation as requested by mid-levels.

B. Collaboration/Supervision/Oversight of Non-Physician Practitioners

1. APRNs function under a Scope of Practice with an assigned collaborating physician.

   a. The APRN is responsible to identify and discuss patient care issues with their collaborating physician in the event of questionable diagnosis or course of treatment.

   b. APRNs are to work with their collaborating physician when requesting initial issuance or renewal of their Scope of Practice.

   c. Collaborating physicians will provide education and counsel to APRNs to discuss cases and/or co-manage cases upon request.

   d. Collaborating physicians will provide input at the time of the APRNs proficiency report.

2. PAs function under a Scope of Practice with an assigned supervising physician.

   a. The PA is responsible to identify and discuss patient care issues with their supervising physician in the event of questionable diagnosis or course of treatment.

   b. PAs are to work with their supervising physician when requesting initial issuance or renewal of their Scope of Practice.

   c. Supervising physicians will provide education and counsel to PAs to discuss cases and/or provide care as needed upon request.

   d. Supervising physicians will provide input at the time of the PA's proficiency report.

C. Documentation of Collaboration/Supervision of Non-Physician Practitioners

1. Sufficient evidence is documented in the medical record to substantiate active collaboration with, and/or supervision of, the patient's care by the attending physician.

2. Entries in the medical record made by non-physician Practitioners may require countersigning by collaborating/supervising physicians. Refer to Medical Records section VI, Paragraph E, below. These entries include, but are not limited to:

   a. Admission Order/Notes

   b. Discharge Summary.

   c. Transfer-related documentation

   d. Operative Reports.

   (NOTE: Because medical orders in EMR do not allow a second signature (co-signature), the physician must either write the orders; 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.)

D. APRN/PA Documentation Requirements for physician citation:

1. APRN/PA practitioners are responsible to consult and collaborate with physician practitioners, as appropriate, to determine a patient's course of treatment. This consultation and collaboration must be accurately reflected in the medical record documentation. The following are guidelines for inclusion/exclusion of physician citation in the medical record:

a. Informal case review – consists of general medical treatment options or general medical care practices, may or may not identify or include details of a specific patient case, is not intended to direct a specific patient's treatment course, patient is not present for exam by physician, mid-level does not request physician conduct patient exam, primary goal of interaction is to gain general medical care knowledge

(1) Clinical documentation should NOT cite another practitioner's name

(2) Additional physician signers should NOT be identified by progress note author

b. Formal case review – review and discussion of clinical findings for an identified patient; includes review of health conditions including lab results, diagnostic test results, patient symptoms, and/or changes in patient condition; patient is present for physician to conduct physical exam, mid-level may request physician conduct physical exam, physician may use clinical judgment and conduct complete or partial clinical examination of patient, primary goal of interaction is to confirm diagnosis and treatment plan for specified patient

(1) Clinical documentation may include practitioner's name and care recommendations of case review

(2) Additional signer is ALWAYS identified by progress note author

(3) The additional signing physician may enter an addendum to the original note or may enter a separate progress note

VI. MEDICAL RECORDS

A. Administrative Staff Entries: 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.

B. Complete Medical Record: The Practitioner is responsible for the preparation and completion of a complete medical record for each patient. This record shall include an updated problem list, identification data, chief complaints, personal history, family history, history of present illness, pertinent physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathological findings, progress notes, doctor's discharge instructions sheet, including condition on discharge (discharge note) and final diagnosis, and final summary.

1. Progress notes will be written by the Practitioner at least once daily on all Acute Inpatient Psychiatry and 50-2 Short-Stay unit patients. Progress notes are written for all patients seen for ambulatory care by the medical staff.

C. Basic Administrative Requirements:

1. Entries must be electronically entered where possible.

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

3. 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.

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

5. Release of information is required in accordance with VHA Handbook 1605.1 using procedures outlined in HCSM Bus-10 and shall only be restricted if the Chief of Staff, or designee determines that the release of specified patient care records can be harmful to the patient.

6. 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.

7. 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.

D. All Medical Records must contain:

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

2. Medical history including history and details of present illness/injury.

3. Observations, including results of therapy.

4. Diagnostic and therapeutic orders.

5. Reports of procedures, tests and their results.

6. Progress notes.

7. Consultation reports.

8. Diagnostic impressions.

9. Conclusions at termination of evaluation/treatment.

10. Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in HCSM CD 11-37 Informed Consent.

E. Inpatient/Resident Medical Records: In addition the items listed in section B above, all inpatient and resident records must contain, at a minimum:

1. 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;

2. 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 practitioner at the earliest possible time, but always within 24 hours of being written in CPRS.

3. A discharge plan (from any inpatient admission or resident), including condition on discharge and discharge instructions.

A completed discharge summary including signature authentication will be consistent with documentation requirements described in Facility policy HCSM BUS 08, Discharge Summaries and Special Medical

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

1. A progress note for each visit.

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

3. Patient disposition and instruction for follow-up care

4. Immunization status, as appropriate

5. Allergies

6. Referrals and communications to other practitioners

7. List of significant past and current diagnoses, conditions, procedures, drug allergies

8. Medication reconciliation

9. Significant problem, and any applicable procedure and operations on the Problem/Summary List

G. Surgeries and Other Invasive Procedures:

1. All aspects of a surgical patient's care, including ambulatory surgery, pre-operative, operative and post-operative care, must be documented. All surgical and invasive procedures which require a next level of care, including inpatient admission or observation of the patient in a recovery area, are subject to the documentation requirements cited within this section. 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. Minor outpatient procedures, done as part of routine ambulatory outpatient care followed by patient disposition to independent living, are exempt from these documentation requirements. These minor outpatient procedures are documented within the outpatient ambulatory care progress note.

2. Preoperative/Pre-procedural Documentation:

   a. In all cases of elective and/or scheduled surgery and/or diagnostic and therapeutic procedures, 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/invasive procedure and signed consent

   b. Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical addressing pertinent clinical 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 as outlined in Rules Section III, Paragraph C, subparagraph 1b above.

   c. Except in an emergency, no patient may go to the operating room without a completed history and physical examination recorded in his/her chart. Recorded results of lab work, x-rays, and other diagnostic tests ordered in preparation for surgery/invasive procedures will be completed and available in the medical record prior to the case.

   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.

3. Immediate Post-Operative/Post-procedural Documentation: A brief post-operative/post-procedure progress note must be directly entered into the patient's health record, by the surgeon/performing practitioner immediately following surgery/invasive procedure and before the patient is transferred to the next level of care to allow for continuing care of the patient.

   a. Exceptions to immediate post-operative/post-procedure note entry requirements:

      (1) If the surgeon/performing practitioner accompanies the patient to the next level of care or is available in the immediate area of the new unit or area of care, then the immediate post-operative/post-procedure note can be written after the patient is transferred to the new unit or area of care so long as the surgeon/practitioner is in the immediate area and available to the staff receiving the patient.

      (2) If the full operative/full procedural report has been completed with the required documentation elements as cited in the post-operative/post procedural documentation section 4 below, ***before*** the patient is transferred to the next level of care, then entry of this immediate post-operative/post-procedural note is not required.

   b. The immediate post-operative note must include:

      (1) Pre-operative diagnosis,

      (2) Post-operative diagnosis,

      (3) Technical procedures used,

      (4) Surgeon/Practitioner(s),

      (5) Findings,

(6) Specimens removed, and

(7) Estimated Blood loss,

(8) Complications.

c. The immediate post-operative note may include other data items, such as:

(1) Anesthesia,

(2) Drains,

(3) Tourniquet Time, or

(4) Plan

4. Post-Operative/Post-Procedural Documentation: An operative/procedure report must be dictated or directly entered into the record and completed by the operating surgeon/procedure Practitioner within 24 hours following surgery/procedure. The body of the report needs to contain the: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative/post-procedural diagnosis; names of the supervising Practitioner, primary surgeon, and assistants; and the presence and/or involvement of the supervising Practitioner. Post-Operative/Post-Procedural dictation is designated priority transcription and will be available for Provider signature as soon as possible, usually within 24 hours. Dictated notes can be accessed through the audio transcription line.

5. 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 practitioner responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.

c. For outpatients that are admitted post-operatively to the CLC for anesthesia-related complications or observation, 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.

VII. INFECTION CONTROL

A. Medical Staff will support and direct adherence to Isolation, Standard Precautions and Reportable Communicable Disease requirements as described in Infection Control Policy HCSM CD 11-25. St. Cloud VAMC has an active Health Care System surveillance, prevention, and control program involving all patient care. All staff will practice good personal hygiene, aseptic techniques, and universal precautions. Diagnosed or suspected cases of "reportable" diseases will be referred to the infection control nurse. Standard precautions will be vigorously enforced for preventing transmission of infectious diseases.

VIII. 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.

All Medical Staff members shall be compliant with VHA and Facility mandatory education requirements to retain appointment as outlined in VA Handbook 5005.

IX. 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. Procedures are outlined in HCSM CD 11-18, Medical Staff Health Policy.

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 Line Medical Director 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 by the PSB.

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.

X. PEER REVIEW/ORGANIZATIONAL SAFETY & ETHICS

A. All Medical Staff members shall participate in the facility protected peer review program outlined in VHA Directive 2010-025 and in accordance with HCSM CD 11-12.

B. All Medical Staff members shall participate in the completion of Office of Medical Inspector Medical Advisory opinions as requested and assigned by the Chief of Staff.

C. All Medical Staff members will comply with adverse event disclosure including:
   1. Open and prompt communication, as appropriate, harmful adverse events with Executive Leaders, patients and/or patients' personal representatives
   2. When necessary, participating in the process for large scale adverse event disclosure
   3. Promoting a ethical health care environment in which appropriate disclosure of adverse events becomes routine practice
   4. Participating as requested or assigned in all Quality Management monitoring activities such as Tort Claim Peer Review, Morbidity and Mortality Reviews, Occurrence Screening, Utilization Review, Medical Records Review, etc.

Adopted by the Medical Staff, VA Health Care System, St. Cloud, MN, on this 3rd Day of April, 2013.

RECOMMENDED

/s/ 6/27/13

S.M. Markstrom, M.D. Date
Chief of Staff

APPROVED

/s/ 8/13/13

Barry I. Bahl Date
Director

REFERENCES:

Joint Commission Accreditation Standards, current edition

VA Handbook 5005, Staffing

VA Handbook 5021, Employee/Management Relations, Parts II, III and IV

VHA Handbook 1050.01 National Patient Safety Improvement Handbook

VHA Handbook 1100.19, Credentialing and Privileging

VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards

VHA Handbook 1100.17, National Practitioner Data Bank Reports

VHA Handbook 1106.01, Pathology and Laboratory Medicine Service Procedures

VHA Handbook 1660.3, Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services, Enhanced Use Leases, Health Care Resource Sharing, Fee Basis, and Intergovernmental Personnel Act Agreements (IPAS)

VHA Handbook 1907.01, Health Information Management and Health Records

VHA Directive 2005-041, The Autopsy as a Critical Component of Quality Management

VHA Directive 2004-029, Utilization of Physician Assistants (PAs)

A. All Medical Staff members shall participate in the facility protected peer review program outlined in VHA Directive 2010-025 and in accordance with HCSM CD 11-12.

B. All Medical Staff members shall participate in the completion of Office of Medical Inspector Medical Advisory opinions as requested and assigned by the Chief of Staff.

C. All Medical Staff members will comply with adverse event disclosure including:
   1. Open and prompt communication, as appropriate, harmful adverse events with Executive Leaders, patients and/or patients' personal representatives
   2. When necessary, participating in the process for large scale adverse event disclosure
   3. Promoting a ethical health care environment in which appropriate disclosure of adverse events becomes routine practice
   4. Participating as requested or assigned in all Quality Management monitoring activities such as Tort Claim Peer Review, Morbidity and Mortality Reviews, Occurrence Screening, Utilization Review, Medical Records Review, etc.

Adopted by the Medical Staff, VA Health Care System, St. Cloud, MN, on this 3rd Day of April, 2013.

RECOMMENDED

S.M. Markstrom, M.D. — 6.27.13 Date
Chief of Staff

APPROVED

Barry I. Bahl — 8/13/13 Date
Director

REFERENCES:

Joint Commission Accreditation Standards, current edition

VA Handbook 5005, Staffing

VA Handbook 5021, Employee/Management Relations, Parts II, III and IV

VHA Handbook 1050.01 National Patient Safety Improvement Handbook

VHA Handbook 1100.19, Credentialing and Privileging

VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards

VHA Handbook 1100.17, National Practitioner Data Bank Reports

VHA Handbook 1106.01, Pathology and Laboratory Medicine Service Procedures

VHA Handbook 1660.3, Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services, Enhanced Use Leases, Health Care Resource Sharing, Fee Basis, and Intergovernmental Personnel Act Agreements (IPAS)

VHA Handbook 1907.01, Health Information Management and Health Records

VHA Directive 2005-041, The Autopsy as a Critical Component of Quality Management

VHA Directive 2004-029, Utilization of Physician Assistants (PAs)

VHA Directive 2007-015, Inter-Facility Transfer Policy

VHA Directive 2008-002, Disclosure of Adverse Events to Patients

VHA Directive 2008-077, Quality Management (QM) and Patient Safety Activities that can generate confidential documents

HCSM BUS-08 Discharge Summaries & Special Medical Reports

HCSM BUS-10 Privacy and Release of Medical Information

HCSM BUS-12 Admission Policy

HCSM BUS-13 Bed Assignments

HCSM CD 00-28 Patient Rights and Responsibilities

HCSM CD 11-03 Organ/Tissue and Eye Donation Policy

HCSM CD11-10 Critical Results Notification

HCSM CD 11-105 Medication Acquisition and Storage

HCSM CD 11-106 Medication Administration

HCSM CD 11-107 Medication Formulary System

HCSM CD 11-108 Medication Prescribing/Ordering – Monitoring

HCSM CD 11-109 Medication – Patient Education

HCSM CD 11-110 Medication – High Risk

HCSM CD 11-111 Medication-VHA All-Hazards Emergency Cache HCSM CD 11-12 Medical Staff/Professional Peer Review

HCSM CD 11-14 Notification of Next of Kin of Seriously Ill, Deaths, and Autopsy Request

HCSM CD 11-16 Medical Executive Board

HCSM CD 11-18 Medical Staff Health Policy

HCSM CD 11-23 Patient Incident Review (PIR) Program

HCSM CD 11-25 Infection Control Program

HCSM CD 11-26 Advance Directives/Psychiatric Advance Directives/Withholding or Withdrawing Life-

Sustaining Treatment HCSM CD 11-27 Code Blue

HCSM CD 11-37 Informed Consent

HCSM CD 11-45 Professional Practice Evaluation

HCSM CD 11-48 Do Not Resuscitate Order/Do Not Intubate Order (DNR/DNI)

HCSM CD 11-49 Integrated Ethics Committee

HCSM CD 11-50 Facility Behavior Committee

HCSM CD 11-53 Assessment, Care and Discharge of Patients

HCSM CD 11-56 Use of Restraints and/or Seclusion

HCSM CD11-69 Computer-Based Medical Record

HCSM CD 11-78 Commitment Guidelines

HCSM CD 11-89 Patient Record Flags (PRF) and Clinical Warnings (CWAD)

HCSM CD 11-90 Medical Records and Documentation Committee

HCSM CD-11-93 Disclosure of Adverse Events to Patients/Next of Kin/Representative

HCSM CD118-01 Nursing Professional Services

HCSM FM-04 Emergency Preparedness Plan (Blue Book)

HCSM Ph\Pharmacy-119 Pharmacist Scope of Practice

HCSM Path & Lab 113-06 Submission of Tissue Samples to Pathology

2. **RESCISSION**: HCSM CD11-05, "Bylaws, Rules and Regulations of the Medical and Clinical Professional Staff" dated April, 2013

3. **REVIEW DATE**: April, 2015

4. **FOLLOW-UP RESPONSIBILITY**: Chief of Staff Office (CD 11)