BYLAWS AND RULES OF THE MEDICAL STAFF

DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER

WEST PALM BEACH, FLORIDA

April 23, 2015

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BYLAWS OF THE MEDICAL STAFF
DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
WEST PALM BEACH, FLORIDA

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for aspects of that care, the Medical Staff practicing at the West Palm Beach VA Medical Center at West Palm Beach, Florida and any facilities owned or operated by such hereby organize themselves for self-governance in conformity with the laws, regulations and policies governing VHA (Veterans Health Administration) and the Bylaws and Rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing VA (Department of Veterans Affairs), and they do not create any rights or liabilities not otherwise provided for in laws or VA Regulations.

DEFINITIONS

1. Medical Staff

The "Medical Staff" shall mean all physicians, dentists, podiatrists, psychologists, and optometrists who have an active, current, full and unrestricted license to practice the individual's profession in a state, territory or commonwealth of the U.S. or the District of Columbia and are employed and granted clinical privileges to provide patient care services for West Palm Beach VA Medical Center.

Categories of Medical Staff

A. Active Staff - Active staff shall consist of all physicians, dentists, podiatrists, psychologists, optometrists and chiropractors with full or part time appointments who are professionally responsible for specific patient care and/or education and/or research activities of the Medical Center and who assume all the functions and responsibilities of membership of the active staff and who are employed by the VA. Only full time members of the Medical Staff are eligible to vote.

B. Other Categories of Medical Staff – Other Categories of Medical Staff shall consist of practitioners who are responsible for supplementing the members of the active Medical Staff in their roles in patient care, education, and research. These members shall be appointed to a specific service and shall be permitted to serve on committees but shall not be required to attend meetings of the Medical Staff. They are not eligible for active staff membership. These categories include:

1. Consultants
2. On station fee basis, contract or sharing agreement
3. Without compensation
4. Intermittent
5. Administrative

C. Associate Members of the Medical Staff include Nurse Practitioners, Certified Registered Nurse Anesthetists, and Physician Assistants who are responsible for supplementing members of the active medical staff in their roles in patient care, education, and research. These health care professionals may have input on-all medical staff issues but do not have voting privileges as medical staff members.

D. Residents - Residents shall consist of professionals who may or may not be licensed to practice medicine, dentistry, podiatry, psychology and optometry, but who are still engaged in a post graduate training program. Their participation in patient care, education, or research shall be under the appropriate supervision of a Medical Staff member who is licensed to practice medicine, dentistry, podiatry or optometry and who has clinical privileges at the Medical Center. Residents are not eligible for membership on the active Medical Staff. They may be permitted to serve on designated Medical Center committees in a non-voting capacity, but shall not be required to attend meetings of the Medical Staff. Mechanisms for supervision of residents are specified in the facility policy on supervision of postgraduate residents. (548-11GME-396 Monitoring of Resident Supervision)

E. Students – Students shall consist of physician, dentist, podiatric, optometric or allied health care professionals who may or may not be licensed to practice their profession, but who are still engaged in an accredited training program. Their participation in patient care education or research shall be under the appropriate supervision as outlined by facility policy. Students are not eligible for membership on the Medical Staff. They may be permitted to serve on designated Medical Center committees in a non-voting capacity, but shall not be required to attend meetings of the Medical Staff. Mechanisms for supervision of students are specified in the facility policy on supervision of students. (548-11GME-395 Supervision of Medical Students)

F. Administrative- There may be practitioners, who by the nature of their position are not involved in patient care (i.e. researchers or administrative physicians). These health care professionals must be credentialed, but may not need to be privileged.

2. Governing Body

The term governing body refers to the Under Secretary for Health, the individual to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the VA Medical Center Director.

3. West Palm Beach VA Medical Center Director

The Director (Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the West Palm Beach VA Medical Center. The Director is assisted by the Chief of Staff, the Deputy Chief of Staff, the Associate Medical Center Director, and Associate Director for Patient Care Services.

4. Physician

Physician shall refer to all doctors of medicine, osteopathy, podiatry, dentistry, optometry and psychology.

5. Practitioner

Practitioner shall refer to physicians, dentists, podiatrists, psychologists, optometrists, nurse anesthetists and nurse practitioners who are fully licensed or otherwise granted authority to practice in a State, Territory or Commonwealth of the U.S. or District of Columbia. Physician assistants are also practitioners who are nationally certified, and thereby, eligible to practice within the VA.

6. Consultant

This term will be used throughout the Bylaws to define a qualified practitioner with clinical privileges who can be called upon for consultations specifically within his/her own area of expertise.

7. Appointment

As used in this document the term 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 for providing patient care services at the West Palm Beach VA Medical Center. Both VA employees and contractors may receive appointments to the Medical Staff.

8. Rules

Refers to the specific rules set forth in this document, which govern the Medical Staff. It does not refer to formally promulgated VA Regulations.

9. VA Regulations

The term VA Regulations means the regulations set forth by the Department of Veterans Affairs (VHA) and made applicable to its health care facilities in compliance with federal laws.

10. Peer

The term Peer means a counterpart or colleague from the same professional discipline who, in general, performs the same type of care and who is deemed capable of assessing the performance, judgment and clinical skills of a health care giver.

11. Verification

As used in this document Verification is defined as primary source documentation by letter, telephone call, or computer printout or, in the case of confirmation of board certification, by listing in the specific directories which list board certification or designated equivalent sources as defined by VA and/or TJC (The Joint Commission).

12. Executive Committee of the Governing Body

The Executive Committee of the Governing Body (ECGB) is the executive level management committee that provides continuity, oversight and review, and integration toactivities involving all subordinate boards, committees, services and interdisciplinary key functions and processes involved in the operations and functions of the Medical Center. The ECGB is chaired by the Medical Center Director who functions as the Chief Executive Officer and Governing Body of the Medical Center. (MCM 548-00-59)

13. VETPRO

VetPro is the electronic credentialing program of the Veterans Health Administration (VHA).

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs Medical Center, West Palm Beach, Florida (WPBVAMC).

ARTICLE II. PURPOSE

The purpose of the Medical Staff shall be to:

A. Ensure that all patients treated at the West Palm Beach VA Medical Center will receive efficient, timely, and appropriate care that is responsive to continuous quality improvement practices. Timeliness for evaluation, care and treatment is defined in current hospital policies.

B. Ensure all patients being treated for the same health problems or with the same methods/procedures receive the same level of care.

C. Establish, and assure adherence to, an ethical standard of professional practice and conduct.

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

E. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed need of caregivers.

F. Ensure a high level of professional performance of practitioners authorized to practice in the facility through continuous performance improvement practices and appropriate delineation of clinical privileges.

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

H. Provide leadership, development, & implementation on the continuous performance improvement activities in collaboration with the staff of the West Palm Beach VA Medical Center.

I. Stimulate research activities and assure that research programs are conducted in keeping with the standards established by the Research and Development committee.

J. Ensure that all patients, their families, visitors, and staff will be treated with courtesy, compassion and respect.

K. Ensure that there shall be medical staff participation and representation in any hospital deliberation affecting the discharge of medical staff responsibilities.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Membership Eligibility

A. Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, dentists, podiatrists, psychologists, chiropractors, and optometrists, who continuously meet the qualifications, standards and requirements of VHA, this VA medical center, and these Bylaws and Rules & Regulations. Membership may be considered for other licensed practitioners who are permitted by law to provide patient care services independently and who meet the qualifications, standards and requirements of VHA, this Medical Center and these Bylaws.

B. Categories of Staff Membership include: Active Staff, Consulting Staff, On-station Fee Basis, Contract (Scarce Medical Specialties), or Sharing Agreement, Without Compensation, Associate Members, Intermittent, Residents/Students and Administrative. These categories may further be subdivided into full time and part time.

C. 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 2. Qualifications for Medical Staff Membership and Clinical Privileges

To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 1 must submit satisfactory 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 the 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. Physician assistants need not be licensed but must be nationally certified by the National Commission on Certification of Physician Assistants (NCCPA). Nurse Practitioners must be certified by the American Nurse Credentialing Center (ANCC) or other nationally-recognized certification program.

B. Education applicable to individual Medical Staff members as defined by regulation.

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

D. Current competence, consistent with the individual's assignment and the privileges 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 granted.

F. Complete information consistent with requirements for application and clinical privileges as defined in Articles IV or V of these Bylaws for a position for which the Medical Center has the patient care need, adequate facilities, support services and staff.

G. Satisfactory findings relative to peer recommendation, previous professional competence and professional conduct.

H. English language proficiency as defined in VA Human Resource regulations.

I. Compliance with the criteria for response time from residence for the applicable service. Reasonable time criteria and the definition of response time shall be determined for each service by the Professional Standards Board after recommendation by the Chief of each service.

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

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

Section 3. Basic Responsibilities of Medical Staff Membership

Medical Staff members are accountable for and have responsibility to:

A. Provide for continuous care of patients.

B. Respect patients' rights.

C. Participate and provide leadership in continuing education, peer review, Medical Staff monitoring, performance improvement activities, patient safety, and oversight in the process of analyzing and improving patient satisfaction.

D. Maintain highest standards of ethics and ethical relationships including a commitment to:

(1) Abide by Federal law and VA rules and regulations regarding financial conflict of interest and outside professional activities for remuneration.

(2) Provide care to patients within the scope of privileges and advise the West Palm Beach VA Medical Center Director through the Chief of Staff of any change in ability to meet fully the criteria for Medical Staff membership or to carry out clinical privileges, which are held.

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

(4) Medical Staff member who are employed full time by VHA may engage in non-VA health care related professional activities outside their scheduled tour of duty as long as those activities do not interfere with call back provisions.

E. Abide by the Medical Staff Bylaws, Rules and Regulations and all other lawful standards and policies of the West Palm Beach VA Medical Center and Veterans Health Administration.

Section 4. Code of Conduct

A. Acceptable Behavior: The West Palm Beach VA Medical Center 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 the Medical Center. Acceptable behavior includes the following (1) being on duty as scheduled. (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by the West Palm Beach VA Medical Center, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the West Palm Beach VA Medical Center to avoid the appearance that one's official actions might be influenced by such gifts.

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

C. Professional Misconduct: Behavior by a professional that creates a violation of ethical standards will not be tolerated.

Section 5. Conflict Management

A. In the event that conflicts arise between the medical staff and the Clinical Executive Board (CEB) on issues including, but not limited to, proposals to adopt a rule,

regulation, or policy or an amendment thereto, the provisions of these Bylaws shall apply. In the event, that the provisions of these Bylaws are insufficient to resolve or successfully manage the conflict, the West Palm Beach VA Medical Center's policy on managing conflict shall apply, as outlined in MCM 548-00E-292 "Alternative Dispute Resolution (ADR) Program". Nothing in the foregoing is intended to prevent members of the medical staff from communicating with the governing body on a rule, regulation, or policy adopted by the Medical Staff of the West Palm Beach VA Medical Center. The governing body shall determine acceptable methods for such communication.

B. If conflicts regarding the medical staff Bylaws, Rules and Regulations, or policies arise between the governing body and the organized medical staff, the organization will follow a conflict management processes that assures the health care safety and quality of care of the patients. The governing body, represented at the West Palm Beach VA Medical Center by the Medical Center Director, will identify an individual with conflict management skills who will meet with two representatives of the medical staff who are not service chiefs, and the involved parties as early as possible to gather information, work with the parties, and if possible, resolve the conflict, protecting the safety and quality of care and practicing a patient centered culture thru the whole process. Care, treatment, and services are provided based on patient needs, regardless of compensation or financial risk-sharing with those who work in the hospital. The governing body and medical staff operate, create policies and procedures, and secure resources and services that support patient safety and quality care, treatment, and services.

ARTICLE IV. APPOINTMENT AND INITIAL CREDENTIALING

Section 1. General Provisions

A. All members of the Medical Staff as defined in Article III, Section 1.b., will be subjected to full credentials review at the time of initial appointment and as outlined in this Article. Credentials that are subject to change during leaves of absence will be subject to review at the time the individual returns to duty.

B. Appointments to the Medical Staff occur in conjunction with VA employment regulations or utilization under a VA contract or sharing agreement. The authority for these actions is based upon:

(1) Provisions of 38 U.S.C. in accordance with Department of Veterans Affairs Manual MP-5, part II, chapter 2, and its supplements; 38 U.S.C. sections 7402(b)(8), and applicable Agreement(s) of Affiliation in force at the time of appointment.

(2) Federal law authorizing VA to contract for health care services.

C. Probationary Period. Initial and certain other appointments made under U.S.C. 7401(1), 7401(3), 5 U.S.C. 3301, are probationary. During the two (2) year probationary period, professional competence, performance and conduct will be closely evaluated under applicable VA

policies and procedures. 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 similar processes to the evaluation of individuals employed under provisions of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements. At the end of the probationary period, if the individual has demonstrated an acceptable level of performance, the probationary status will be converted to a career appointment. Appointment of properly licensed non-citizen individuals with a permanent immigration visa will be considered temporary and subject to annual review of performance.

Section 2. Application Procedures

A. Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA Handbook 1100.19. To be complete, applications for appointment must be submitted by the applicant on forms approved by the VA and/or the facility and include authorization for release of information pertinent to the applicant and information as listed below:

(1) Items specified in Article III, Section 2, Qualifications for Medical Staff Membership:

(a) Active, current, full and unrestricted license to practice the individual's profession in a state, territory or commonwealth of the U.S. or the District of Columbia or national certification by NCCPA for physician assistants and national certification by ANCC or VA-recognized certification program for nurse practitioners.

(b) Relevant education,

(c) Relevant training and/or experience,

(d) Current clinical competence and conduct as evidenced by performance information that bears on the applicant's credentials.

(e) Physical and mental health status,

(f) Response time from residence as defined in Article III, Section 2, paragraph (i).

(g) English language proficiency, as defined in VA Human Resource regulations.

(h) Professional Liability Insurance history. When a non-VA practitioner applies for Medical Staff appointment and/or clinical privileges professional liability insurers will be contacted. Applicants must supply any present or past involvement in administrative, professional or judicial proceedings in which professional malpractice is or was alleged. The details

will include name of action or proceeding, date filed, court or reviewing agency, status or disposition of case concerning allegation together with an explanation by applicant of the circumstances involved.

(2) U.S. Citizenship. Applicant must be a citizen of the United States. However, 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. Proof of current VISA status and documentation from Immigration and Naturalization Service of employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3 will be required

(3) References. Where possible, names and addresses of a minimum of three (3) individuals one of which is from the most recent supervisor or Program Director 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. One of the references must be provided by a peer. Peer recommendations include written information regarding the practitioner's current Medical / Clinical Knowledge, Technical and Clinical Skills, Clinical Judgment, Interpersonal Skills, Communication Skills, and Professionalism.

(4) Previous Employment. List of all health care institutions where the practitioner is/has been appointed, utilized or employed, including:

(a) Name of health care institution or practice,

(b) Term of appointment or employment, and

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

(5) DEA (Drug Enforcement Administration)/ CDS (Controlled Dangerous Substances) registration.

(a) Of those who have, or have had, DEA registration.

(b) Previously successful or currently pending challenges to DEA/CDS registration or the voluntary or involuntary relinquishment of such registration.

(6) Current pending challenges to license or registration, including whether a license or registration ever held to practice a health occupation by the practitioner has been suspended, revoked, voluntarily surrendered or not renewed.

(7) Status of any claims made against the practitioner in the practice of any health occupation. (**NOTE: Final judgments or settlements of professional liability actions are minimum requirements.**)

(8) Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at other health care facilities.

(9) Current pending challenges against the practitioner by any hospital, licensing board, law enforcement agency, professional group or society.

(10) 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.

B. Documents required in addition to those listed include:

(1) Documentation of current or most recent clinical privileges held, if applicable or available.

(2) Verification of status of licenses for all states in which the applicant has ever held a license.

(3) For foreign medical graduates, evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate and/or a fifth pathway route of training.

(4) Evidence and verification of current board certification in an area relevant to the privileges requested, by a VA recognized physician board.

(5) Verification of education credentials used to qualify for appointment (and privileges) including all postgraduate training.

(6) Evidence of registration with the NPDB (National Practitioner Data Bank) Continuous Query Update for all members of the Medical Staff and those practitioners with clinical privileges.

(7) 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 must be obtained.

(8) Testimony, by the applicant, of their physical and mental ability to perform the privileges, which they seek.

(9) Agreement to abide by the Medical Staff Bylaws, Rules and Regulations and to provide continuous care of applicant's patients.

C. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper processing and evaluation of 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 may serve as a basis for denial of employment consideration.

NOTE: Verification is defined as primary source documentation by letter, telephone call, computer printout or, in the case of confirmation of board certification, by listing in specific directories, as outlined in VHA policies on Credentialing and Privileging and VHA Handbook 1100.19.

Section 3. Process and Terms of Appointment

A. The appropriate service chief is responsible for recommending appointment to the Medical Staff. The Chief of Staff is responsible for recommending appointment of Service Chiefs. The Chief of the appropriate clinical service recommends appointment of the Chief of Staff. This recommendation is based on evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.

B. In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be submitted to the VISN 8 Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the Clinical Executive Board if the response from the NPDB continuous query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of $550,000 or more, or (c) two medical malpractice payments totaling $1,000,000 or more. The higher level review by the VISN 8 CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN 8 CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN 8 CMO review will be documented on the Service Chief's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

C. The Professional Standards Board (PSB) recommends a Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met. This recommendation is forwarded to the CEB for final recommendation. The recommendation of the CEB is subject to final approval by the Medical Center Director.

D. Appointments to the Medical Staff should be acted upon by the Medical Center Director within 30 days of receipt of a fully complete application including all required verifications, references and recommendations from the appropriate Service Chief, PSB and CEB. Applicants shall enter on duty (EOD) within ninety (90) days of approval by the Professional Standards Board. Appointees who do not meet this requirement must be re-presented to the Professional Standards Board for consideration of adverse occurrences between the time of initial Board approval and EOD date. The term of appointment is for a period not to exceed two (2) years.

NOTE: In conformity with VA Rules and Regulations, appointments of certain clinically privileged employees are based on recommendations of "Standards Boards" which differs from the West Palm Beach VA Medical Center Professional Standards Board. In all cases where recommendations are made by any Standards Board, whether it is the West Palm Beach VA Medical Center Professional Standards Board or other "Standards Boards", in order to conform to VA Rules and Regulations, these recommendations are forwarded to the CEB for their approval and for final approval by the Medical Center Director.

E. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment. In the case where appointment is not approved, reasons will be provided.

F. Temporary Appointment. When there is an emergent or urgent patient care need, a temporary VA employment appointment, under provisions of 38 U.S.C. 7405(a)(1) and VHA Supplement MP-5, part II, chapter 2, temporary Medical Staff appointment, may be approved by the West Palm Beach VA Medical Center Director, upon recommendation of the Chief of Staff, prior to receipt of all references or verification of other information and action by the Professional Standards Board and CEB. Verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted and a reference will be obtained prior to making such an appointment. National Practitioner Data Bank – Healthcare Integrity and Protection Data Bank (NPDB-HIPDB) report will be obtained on the applicant to be considered with the application.

Section 4. Credentialing for Telehealth and Teleconsultation

When the staff of a facility determines that telemedicine and/or teleconsultation is in the best interest of quality patient care, appropriate credentialing and privileging is required between the Providing Facility and the Receiving Facility.

A. Telehealth providers will be credentialed and privileged to practice at the *Providing Facility*. Telehealth providers do not need to be credentialed and privileged at the *Receiving Facilities* so as long as the provider's practice is limited to the privileges granted by the *Providing Facility* and accepted by the *Receiving Facility* as noted in the Memorandum of Understanding and the Telehealth Service Agreement.

1. The practitioner providing the telemedicine and/or teleconsultation services must be credentialed and privileged in accordance to VHA Handbook 1100.19.

2. Competency reviews will be performed at every center where the telehealth provider is privileged.

3. The Providing Facility will be responsible and accountable for ensuring that the telehealth providers are credentialed and privileged in compliance with the Joint Commision standards for the telehealth providers.

ARTICLE V. CLINICAL PRIVILEGES

Section 1. General Provisions

A. Medical Center specific privileges are granted for a period not to exceed two (2) years.

B. Biennial reappraisal of each Medical Staff member and any other practitioner who holds clinical privileges is required. This reappraisal is instituted by the practitioner's Service Chief at the time of a request by the practitioner for new or renewed clinical privileges. Reappraisal includes a review of performance by someone with comparable privilege, an evaluation of the individual's physical and mental status, and an assessment of the individual's current privileges. It also requires verification of satisfactory completion of sufficient continuing education to satisfy a minimum requirement of 40 hours of continuing education every two years. The amount of continuing education relevant to current privileges is determined by the Service Chief.

C. A practitioner's request for modification/enhancement of existing clinical privileges is made by the practitioner through submission of a formal request for desired changes with full documentation to support the change.

D. Certain other practitioners which include but are not limited to nurse practitioners, physician assistants, Certified Registered Nurse Anesthetists (CRNAs), and clinical nurse specialists who are presently permitted by law and the West Palm Beach VA Medical Center to provide patient care services may be granted clinical scope of practice based on their assignments, responsibilities and demonstrated competence.

E. Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of their appointment type, utilization authority, or their professional discipline. Although the reappraisal process occurs biennially, Ongoing Professional Practice Evaluation is designed to continuously evaluate a practitioner's performance.

F. Practitioners with clinical privileges are assigned to and have clinical privileges in one clinical department/service, but may be granted clinical privileges in other clinical departments/services. If new privileges are requested, a proctorship may be initiated requiring the provider to perform a specified number of procedures within an allotted time period to validate competence.

G. Exercise of clinical privileges within any service is subject to the rules of that service and by the authority of that Service Chief. Practitioners practice only within the scope of their privileges that have been granted.

H. A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The initial and the updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, a maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA and hospital policy. The content of complete and focused history and physical examination is delineated in Section 7.E.: Medical Records, of the Medical Staff Rules and Regulations.

H. Admitting Privileges - Only members of the active Medical Staff are eligible to be granted the privilege to admit patients to the acute, critical, or Community Living Center of the facility. Physicians and oral-maxillofacial surgeons with admitting privileges have the responsibility for taking the medical history and conducting a comprehensive physical examination and required updates on patients admitted for inpatient care. The process of taking the medical history and conducting a comprehensive physical examination and required updates may be delegated to physician assistants or nurse practitioners. However, in all cases, the attending physician of record bears the responsibility for the accuracy and completeness of the history and physical and required updates. When an oral-maxillofacial surgeon admits to inpatient services, the provision is made for the prompt medical evaluation of these patients by a qualified physician, if a risk or condition requiring such evaluation is discovered by the oral-maxillofacial surgeon during the admitting history and examination. Dentists are responsible for that part of the patient's history and physical examination related to oral pathology. Some dentists, because of their training and experience, may be privileged to perform the admitting history and physical and required updates. Dentists possessing such credentials must request and be granted these privileges. A patient's general medical condition will be the responsibility of a qualified designated physician irrespective of the illness, management, or reason for admission.

I. Special Conditions for Dental Privileges - Requests for clinical privileges from dentists shall be processed, evaluated and granted in the same manner as physicians. Surgical procedures performed in the operating suite shall be under the overall supervision of the Chief of Surgical Service. Patients admitted to the Medical Center for dental care or any type of oral pathology shall receive the same basic medical appraisal as patients admitted for any other reason. A designated physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The admitting dentist shall determine the risk and effect of the proposed surgical procedures through performance of the admitting H&P and will consult with a physician member of the Medical Staff on the total health status of the patient, as necessary.

J. Clinical Direction of Specialty Care Units - Overall clinical direction of Specialty Care Units is vested in multidisciplinary committees of the Medical Staff; namely Critical (Intensive) Care and End stage Renal Disease Committees. The Chairman of the Critical Care Committee and the End Stage Renal Disease Committee shall be a physician member of the Medical Staff. Upon recommendation of the Chief of Staff, the Medical Center Director shall appoint the Chairman of the Critical Care Committee and the Chairman of the End stage Renal Disease Committee. Responsibilities of the Chief of Critical Care Units and Renal Dialysis Unit will be in accordance with the respective Medical Center Policy Memorandum.

K. Determination of Organization Resource Availability – The Clinical Service Chief makes an assessment to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within 90 days to support each requested privilege.

Section 2. Process and Requirements for Requesting Clinical Privileges

A. Burden of Proof. The practitioner requesting clinical privileges must furnish all information needed for a proper evaluation of professional competence, conduct, ethics, and other qualifications. The information must be complete and verifiable. The practitioner is responsible for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days may serve as a basis for denying the processing of the request for clinical privileges.

B. All practitioner requests for clinical privileges must be made in writing and include privileges requested "within well-defined limits" as defined by each Service, in a format approved by the CEB upon recommendation of the Professional Standards Board. Each application for clinical privileges will be accompanied by signed consents to the inspection of records and documents, pertinent to the applicant's licensure, specific training, experience, current competence, and ability to perform the privileges requested. If requested, the applicant will appear for an interview.

C. The practitioner applying for reappraisal of clinical privileges must submit a complete application for privileges, which will include:

(1) Complete appointment information as outlined in Section 2 of Article IV.

(2) Application for clinical privileges as outlined in Section 2b of this Article.

(3) Documentation of current Basic Life Support (BLS) for all Healthcare Providers.

Exceptions to the BLS requirement may only be made by the PSB. Staff members with physical restrictions are still responsible for completing didactic portion of BLS training.

(4) Documentation of current Advanced Cardiac Life Support (ACLS) if the staff member is an emergency, critical care, or hospitalist provider; is in code blue or rapid response team, or has moderate sedation or anesthesia privileges.

D. A practitioner's request for modification to clinical privileges subsequent to those granted initially will initiate the re-credentialing process and the practitioner must provide the following information:

(1) An application for clinical privileges as outlined in Section 2b of this Article. (Since practice, techniques, and facility missions change over time, it is expected that modifications, additions or deletions to existing clinical privileges will occur. Practitioners are urged to consider carefully and discuss appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of the request.)

(2) Supporting documentation of professional training and/or experience not previously submitted.

(3) Physical and mental health status as it relates to practitioner's ability to perform privileges requested including such reasonable evidence of health status that may be required by either the Professional Standards Board or the Physical Standards Board.

(4) Documentation of continuing medical education related to area and scope of clinical privileges not previously submitted. Continuing educational requirements will be determined by the Professional Standards Board after recommendations by the Continuing Medical Education (CME) Committee.

(5) Status of all licenses, certifications held.

(6) Any sanction(s) by a hospital, state licensing agency or any other professional health care organization; voluntary or involuntary relinquishment or current pending challenges of appointment, privileges, licensure or registration; any malpractice claims, suits or settlements (e.g., final judgments or settlements); or voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of privileges at any other hospital within 15 days of an adverse action.

(7) Response time from residence to facility.

(8) Names of other hospitals at which privileges are held, copies of the privileges held and provider profile data for privileges requested. When possible, the copies of the privileges will be obtained from primary source verification and not from the applicant.

(9) Information from the practitioner's professional practice evaluation data that are collected and assessed on an ongoing basis, if available.

E. Bylaws Receipt and Pledge. Prior to the granting of clinical privileges, Medical Staff members or applicants will pledge to provide for continuous care of their patients and will receive a copy of the Bylaws and Rules and agree in writing to abide by the professional obligations therein.

F. Verification

(1) Verification of credentials prior to granting of initial privileges will be accomplished as described in Article IV, Section 2, "Appointment and Initial Credentialing".

(2) Before granting subsequent clinical privileges, the Chief of Staff will assure that the following information is on file and verified with the primary sources, as applicable:

(a) Current and former licenses in all states.

(b) Current and former DEA license and/or registration.

(c) National Practitioner Data Bank query.

(d) Physical and mental health status information from applicant indicating their ability to practice in the area in which they are requesting privileges. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external or internal source may be required as prescribed by VHA Human Resource Policy.

(e) Physical and mental health confirmation and confirmation of applicant's ability to perform privileges requested by Service Chief (or other officials at discretion of PSB).

(f) Continuing education to meet any local requirements for privileges requested.

(g) Board certification(s).

(h) Quality of care information.

(i) Number and outcome of procedures performed (over the last two-year period) if requesting privileges for any type of procedure. If quantitative data is not available, qualitative outcomes data from facility where privileged is required.

(j) Malpractice information (if any) and verification of professional liability insurer(s') information on the applicant, if applicable. This information will be verified on each applicant.

(k) Documentation of current BLS for all Healthcare Providers.

Exceptions to the BLS requirement for medical staff members may only be made by the Chief of Staff. A waiver can be granted when it is determined that it is the best interest of Veteran care and access to care and shall not exceed 60 days per VHA Directive 1177. Staff members with physical restrictions are still responsible for completing didactic portion of BLS training.

(l) Current documentation of ACLS if required for privileges requested.

(m) Current documentation of Moderate Sedation Training, Out of OR Airway Management (OOORAM) training & skills checklist, fluoroscopy training, or evidence of use of laser training if required for privileges requested.

G. Other Specified Professional Staff - In accordance with VA regulations and upon recommendation of the respective Service Chief, Professional Standards Board and the CEB, and after verification of all the necessary documents clinical privileges may be granted to other specified professional staff. These staff members will <u>not</u> be members of the active Medical Staff and may include, but are not limited to clinical nurse specialists, registered nurses, dental hygienists, dental technicians, imaging technicians, laboratory technologists, and social workers. Individuals must meet VA qualification standards and will be administratively responsible to the respective Service Chief and professionally responsible to supervising physicians or dentists for medical or dental aspects of patient care. Responsibilities will be carried out in accordance with service policies and procedures and Medical Staff Bylaws, Rules and Regulations. Service Chiefs are responsible for biennial reviews and recommendations to the Clinical Practice Council for scope of practice. The submission of these scopes of practice statements to the Medical Center Director through the appropriate Clinical Practice Council will be processed in accordance with MCM 548-11-136 "Clinical Functions under Scope of Practice."

Section 3. Credentials Evaluation and Maintenance

A. Competence - A determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the practitioner applying for clinical privileges, has demonstrated current competence in Medical / Clinical Knowledge, Technical and Clinical Skills, Clinical Judgment, Interpersonal Skills, Communication Skills, and Professionalism to practice with clinical privileges requested.

B. A review of the practitioner's performance within the organization is included in the consideration to renew privileges.

C. Verification - Effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as two requests for verification 30 days apart.

D. A Credentialing and Privileging folder will be established and maintained for each practitioner requesting privileges. These folders will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging. At any time that a folder is found to lack required documentation for any reason, effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be made in the folder stating that reason. The entry will also detail the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. Credentialing and privileging folders will be located in the Medical Staff Office, and remain under lock and key.

E. 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 Clinical Executive Committee. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (VHA Handbook 1100.19, Chapter 13.c.(4)).

Section 4. Professional Practice Evaluation

Professional practice evaluation is a service-specific process that allows the Medical Staff to identify professional practice trends that have an impact on the quality of care and patient safety. This evaluation of an individual practitioner's professional performance includes opportunities to improve care based on recognized standards. Individual evaluation is based on generally recognized standard of care. This process provides confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.

Focused Professional Practice Evaluation

A. Focused professional practice evaluation (FPPE) is a process whereby the Professional Standards Board of the Medical Staff (PSB), as delineated by the CEB, evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. FPPE process is implemented for all initially requested privileges. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. The triggers that indicate the need for performance monitoring shall be clearly defined. The triggers can be single incidents or evidence of a clinical practice trend which affects the provision of safe, high quality patient care. An FPPE will be recommended by the Service Chief with a written request to the PSB. Focused professional practice evaluation is a time-limited period during which the PSB evaluates and determines the practitioner's professional performance.

B. The focused evaluation process is determined by the Professional Standards Board considering recommendations of the Service Chief. The time period of the evaluation can be extended by the PSB, and/or a different type of evaluation process assigned. Information for focused professional practice evaluation may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each. Relevant information resulting from the focused evaluation process is integrated into performance improvement activities in a manner intended to preserve confidentiality and privilege of information.

C. The medical staff member who is subject to FPPE will be informed of the evaluation criteria and the evaluation results and recommendations based on results upon completion of the FPPE. The medical staff is responsible for full compliance to the evaluation criteria established by the CEB and approved by the Medical Center Director. Non-compliance to the FPPE process will be subject to appropriate administrative actions and/or loss of privileges relating to the FPPE.

D. Monitoring and evaluation by an external source may be required for the following circumstances: non-availability of practitioners with equivalent privileges or conflict of interest among practitioners involved in the evaluation process.

Ongoing Professional Practice Evaluation

A. Ongoing Professional Practice Evaluation (OPPE) is defined as ongoing data review and findings about the practitioner's practice and performance and will be documented every six months. The OPPE is used to assess the quality of care of each practitioner at the time of reappointment to the Medical Staff. Ongoing evaluation may also identify patterns, outcomes, complications or other indicators associated with the practice of a specific practitioner, which suggests the need for a FPPE.

B. The OPPE should reflect the practitioner's area of expertise and be evaluated by the Service Chief and reviewed with the practitioner biannually. The type of data complied within the OPPE will be determined by the Service Chief and reviewed with the practitioner prior to being presented at the Professional Standards Board at the time of reappointment.

C. A service and/or specialty-specific professional practice evaluation form is developed and implemented for each practitioner incorporating the six areas of "General Competencies" adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

1. Patient Care
2. Medical/Clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Section 5. Recommendations and Approval

A. Peer recommendation(s) will be obtained from individuals who can provide authoritative information regarding training/ experience, professional competence and conduct, and health status. Peer recommendations include written information regarding the practitioner's current Medical / Clinical Knowledge, Technical and Clinical Skills, Clinical Judgment, Interpersonal Skills, Communication Skills, and Professionalism.

B. The Service Chief to whose service the applicant for clinical privileges is assigned is responsible for assessing all information and recommending approval of clinical privileges. If it is a Service Chief who is the applicant, then the Chief of Staff will be responsible for assessing all information and recommending approval of clinical privileges.

(1) Recommendation for initial privileges will be based on determination that the applicant meets criteria for appointment and clinical privileges for the service including requirements regarding education, training, experience, references, health status and documented evidence of activity/case log of procedures, as outlined in privileges requested.

(2) Recommendation for clinical privileges subsequent to those granted initially will be based on, at least, reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skill, pattern and number of professional liability actions resulting in a final judgment against the applicant, relevant practitioner-specific data as compared to aggregate data (when available), risk adjusted morbidity and mortality data (when available), and results of monitoring and evaluation activities.

(3) Past performance notwithstanding, clinical privileges will only be granted for treatments and procedures performed at this Medical Center.

(4) Peer recommendations include information on relevant training and experience, current competence, any effects of health status on privileges being requested. Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice.

C. The Clinical Executive Board upon the recommendation of the Professional Standards Board recommends granting clinical privileges based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws.

D. Clinical privileges are acted upon by the Medical Center Director within 45 days of receipt of a fully complete application for clinical privileges that includes all requirements set forth in Article V, Section 2.

E. If applicants for the Medical Staff do not enter on duty within 45 days of the Medical Center Director's approval of privileges, the following will be required prior to entry on

duty (EOD); a second NPDB query and a report of contact completed by the applicant's service chief attesting to the applicant's current competency.

F. Originals of approved clinical privileges documents are placed in the individual practitioner credentialing and privileging folder. Copies are distributed to the practitioner and Service Chief. Clinical Privileges are available on the U Drive: Clinical Privileges folder to allow access by appropriate staff on an as needed basis.

Section 6. Privilege Decision Notification

A. The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within fifteen (15) business days following the decision of the Executive Committee of the Governing Body.

B. In the case of privilege denial, the applicant is informed of the reason for denial by the Service Chief.

C. The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal entities. The decision to grant, deny, revise, or revoke privilege(s) may be reportable to external persons or entities as required by law and/or VHA Policies including VHA Handbook 1100.17 National Practitioner Data Bank Reports and VHA Handbook 1100.18 Reporting & Responding to State Licensing Boards.

D. In the case of a decision to limit or deny requests for privileges, the Service Chief makes the practitioner aware of the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions as described in ARTICLE VI of these Bylaws.

Section 7. Exceptions – Emergency Care, Expedited, Temporary and Disaster Privileges

A. **Emergency Care, treatment, and services** may be provided by any medical staff member with clinical privileges as a life-saving measure or to prevent serious harm—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment and services provided are within the scope of the individual's license. Disaster privileges should entail a description for oversight of performance/competency of volunteer licensed independent practitioners who are granted disaster privileges. Emergency care may also be provided by properly supervised trainees.

B **Expedited Appointment to the Medical Staff.** There may be instances where expediting a medical staff appointment for LIPs is in the best interest of quality patient care.

(1) The credentialing process for the Expedited Appointment to the Medical Staff cannot begin until the LIP completes the credentials package, including but not limited to a complete application; therefore, the provider must submit this information through VetPro and documentation of credentials must be retained in VetPro.

(2) Credentialing requirements for this process must include confirmation of:

(a) The physician's education and training (which, if necessary, can be accomplished in 24 hours through the purchase of the American Medical Association's Physician Profile);

(b) One active, current, unrestricted license verified by the primary source State, Territory, or Commonwealth of the United States or in the District of Columbia; ***NOTE:*** *To be eligible for appointment, a practitioner must meet current legal requirements for licensure (see 38 U.S.C. §7402(b) and (f), and preceding subpar. 2b.*

(c) Confirmation on the declaration of health, by a qualified, licensed physician designated by or acceptable to the West Palm Beach VA Medical Center of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;

(d) Query of licensure history through the FSMB Action Data Center with no report documented;

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

(f) Current comparable privileges held in another institution; and

(g) NPDB-HIPDB PDS registration with documentation of no match.

(3) If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted; and there is no history of malpractice payment, a delegated subcommittee of the Executive Committee of the Medical Staff, consisting of at least two members of the full committee, may recommend appointment to the medical staff. Full credentialing must be completed within 60 calendar days and presented to the Executive Committee of the Medical Staff for ratification.

(4) The expedited appointment process may only be used for what are considered "clean" applications. The expedited appointment process cannot be used:

(a) If the application is not complete (including answers to Supplemental Questions, Declaration of Health, and Bylaws Attestation); or

(b) If there are current or previously successful challenges to licensure; or

(c) If there is any history of involuntary termination of medical staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges; or

(d) If there has been a final judgment adverse to the applicant in a professional liability action.

(e) If the provider is excluded per review of the DHHS OIG's List of Excluded Individuals and Entities (LEIE) from receiving or directing the expenditure of Federal health care funds for items or services the provider provides, orders, or prescribes while excluded

(5) This recommendation by the delegated subcommittee of the Executive Committee of the Medical Staff must be acted upon by the Medical Center Director. The 60 calendar days for the completion of the full credentialing process begins with the date of the Director's signature.

(6) Expedited appointment to the medical staff process does not relieve the West Palm Beach VA Medical Center from any appointment requirements as defined by the Human Resources Management Program and acquisition requirements.

(7) For those providers where there is evidence of a current or previously successful challenge to any credential or any current or previous administrative or judicial action, the expedited process cannot be used and complete credentialing must be accomplished for consideration by the Executive Committee of the Medical Staff.

(8) This is a one-time appointment process for initial appointment to the medical staff and may not exceed 60 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 60 calendar days of the Expedited Appointment or the medical staff appointment is automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director, even though ratification of the appointment is accomplished within 60 calendar days (the effective date does not change).

C. **Temporary Medical Staff Appointments for Urgent Patient Care Needs.** ***NOTE:*** *Temporary appointments are for emergent or urgent patient care only and NOT to be used for administrative convenience.*

(1) Urgent patient care needs may require appointment before full credentialing information has been received. Since credentialing is a key component in any patient safety program, the appointment of providers with less than complete credentials packages warrants serious consideration and thorough review of the available information.

Temporary medical staff appointments can only be made when the following criteria are met:

(a) A situation where a physician becomes ill or takes a leave of absence and a LIP would need to cover the physician's practice until the physician returns.

(b) A situation where a specific LIP with specific skill is needed to augment the care to a patient that the patient's current privileged LIP does not possess.

(c) Any other situation in which the Chief of Staff determines that there is an urgent patient care need necessitating a temporary Medical Staff appointment.

(2) The facility must use defined criteria for those instances, which may include the preceding examples, in which Temporary Appointments for Urgent Patient Care Needs are appropriate. Criteria must include the circumstances under which they will be used and the applicant criteria.

(3) When there is an emergent or urgent patient care need, a temporary appointment may be made, in accordance with VA Handbook 5005, Part II, by the facility Director prior to receipt of references or verification of other information and action by a Professional Standards Board. Minimum required evidence includes:

(a) Verification of at least one, active, current, unrestricted license with no previous or pending actions;

(b) Confirmation of current comparable clinical privileges;

(c) Response from NPDB Continuous Query registration with no match;

(d) Response from FSMB with no reports;

(e) Receipt of at least one peer reference who is knowledgeable of and confirms the provider's competence, and who has reason to know the individual's professional qualifications; and

(f) Documentation by the Medical Center Director of the specific patient care situation that warranted such an appointment.

***NOTE**: An application for Temporary Appointment for Urgent Patient Care needs, must be a "clean" application with no current or previously successful challenges to licensure; no history of involuntary termination of medical staff membership at another organization; no voluntary limitation, reduction, denial, or loss of clinical privileges; and no final judgment adverse to the applicant in a professional liability action.*

(4) Temporary appointments must be completed in VetPro including the NPDB-HIPDB PDS registration and response, and the FSMB query and response. These appointments may not be renewed or repeated.

(5) An application through VetPro must be completed within 3 calendar days of the date the appointment is effective. This includes Supplemental Questions, a Declaration of Health, and a Release of Information. This additional information facilitates the required completion of the practitioner credentialing for these practitioners used in urgent patient care needs situations, as well as providing additional information for evaluation of the current Temporary Appointment and reducing any potential risk to patients.

(6) If the Temporary appointment is not converted to another form of medical staff appointment, complete credentialing must be completed, even if completion occurs after the practitioner's temporary appointment is terminated or expires. At a minimum, the LIP must submit a VetPro application, and all credentials must be verified. If unfavorable information was discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

NOTE: *Temporary appointments for urgent patient care needs may not exceed the length of time of the Temporary appointments.*

D. Disaster Privileges

(1) Disaster privileges are privileges granted in an extreme emergency when current Medical Staff is insufficient for the number of victims or the scope of injuries. Disaster privileges may be granted to ensure an adequate number and skill mix of medical staff during time of disaster only after the Medical Center Director has activated the Emergency Management Plan.

(2) Once the Emergency Management Plan is activated by the Medical Center Director, the Chief of Staff is responsible for determining if additional medical staff is needed and for initiating the use of disaster privileges.

(3) The Medical Center Director may grant disaster privileges as needed to practitioners who are not members of the Medical Center's medical staff. This responsibility may be delegated to the Chief of Staff. These privileges would typically be granted for a period of up to 72 hours until temporary privileges can be granted.

(4) Medical professionals included in medical staff membership with a current license may be utilized in their area of practice by presenting to the Medical Center Director, Chief of Staff or Medical Staff Coordinator a current license and a valid photo ID issued by a state, federal or regulatory agency. The Emergency Operations Center will issue a temporary ID to staff

(5) The Medical Staff Coordinator is responsible for converting disaster privileges to temporary privileges as soon as feasibly possible. This should be completed within 72 hours from the time the volunteer practitioner presents to the organization except in the case of extraordinary circumstances that prevent primary source verification (e.g., no means of communication or a lack of resources). In this case, the primary source verification must be completed as soon as feasibly possible and the following must be documented:

(a) The reason why primary source verification could not be performed in the required time frame;

(b) Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and,

(c) An attempt to rectify the situation as soon as possible.

(6) Medical Staff Members and/or Service Chiefs are responsible to oversee the professional performance of volunteer practitioners who are working in their service who receive disaster privileges. Oversight can be accomplished through direct observation, mentoring, and/or clinical record review.

(7) Disaster privileges will be considered void after the disaster has ended or temporary privileges are granted, whichever occurs first.

Section 8. Exceptions – Deployment and/or Activation Privilege Status

Deployment and/or Activation Privilege Status. In those instances where a provider is called to active duty, the provider's privileges are to be placed in a Deployment and/or Activation Status. The credential files continue to remain active with the privileges in this new status. If at all possible, this process for returning privileges to an active status must be communicated to providers before deployment.

(1) Providers returning from active duty must be asked to communicate with the medical center staff as soon as possible upon returning to the area. ***NOTE:*** *This will hopefully occur with as much lead-time as possible.*

(2) The provider must update the electronic Credentials File after the file has been reopened for credentialing updating licensure information, health status, and professional activities while on active duty.

(3) The credentials file must be brought to a verified status. If the provider performed clinical work while on active duty, an attempt must be made to confirm the type of duties, the provider's physical and mental ability to perform these duties, and the quality of the work; this information must be documented.

(4) The verified credentials, the practitioner’s request for returning the privileges to an active status, and the service chief's recommendation are to be presented to the medical staff’s Executive Committee for review and recommendation. The decision of the medical staff’s Executive Committee must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and forwarded to the Director for recommendation and approval of restoring the provider's privileges to Current and Active Status from Deployment and/or Activation Status.

(5) In those instances when the practitioner’s privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.

(6) In those instances where the privileges lapsed during the call to active duty, the provider needs to provide additional references for verification and the medical center staff needs to perform all verifications required for reappointment.

(7) In those instances where the provider was not providing clinical care while on active duty, the provider in cooperation with the Service Chief, Clinical Executive Board, and/or the Executive Committee of the Medical Center must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges needs to be initiated, on a short-term basis.

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

(a) Verification of all licenses that was current at the time of deployment and/or activation as current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.

(b) Registration with the NPDB-HIPDB PDS with no match.

(c) A response from the FSMB with no match.

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

(e) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

NOTE: *No step in this process should be a barrier in preventing the provider from returning to the medical center in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.*

ARTICLE VI. FAIR HEARING AND APPELLATE REVIEW PROCEEDINGS

General Provisions

A. Reduction and revocation of clinical privileges may be separate from the reappraisal and reprivileging process. Data gathered in conjunction with the facility's performance improvement activity is an important tool for identifying potential deficiencies. Material, which 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.

B. Reduction and revocation of privileges. A reduction of privileges may include restricting or prohibiting performance of selected specific procedures, or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area. Revocation of privileges refers to the permanent loss of clinical privileges.

C. **Automatic Suspension of Privileges.** Privileges may be automatically suspended for administrative reasons which may occur in instances where the provider is behind in dictation, or allowed a license to lapse and therefore does not have an active, current, unrestricted license.

(1) Such instances must be weighed against the potential for substandard care, professional misconduct, or professional incompetence. A thorough review of the circumstances must be documented with a determination of whether the cause for the automatic suspension does or does not meet the test of substandard care, professional misconduct, or professional incompetence.

(2) Under no circumstances should there be more than three automatic suspensions of privileges in 1 calendar year, and no more than 20 days per calendar year. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in a calendar year, a thorough assessment of the need for the practitioner's services needs to be performed and documented and appropriate action taken. Any action is to be reviewed against all reporting requirements.

D. **Summary Suspension-** Clinical privileges may be summarily suspended when the failure to take such an action may result in an imminent danger to the health of any individual. Summary suspension pending comprehensive review and due process, as outlined in the section on the reduction and revocation of clinical privileges, is not reportable to the NPDB. However, the notice of summary suspension to the practitioner needs to include a notice that if a final action is taken, based on professional competence or professional conduct grounds, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. The notice of summary suspension needs to contain a notice to the individual of all due process rights.

When privileges are summarily suspended, the comprehensive review of the reason for summary suspension must be accomplished within 30 calendar days of the suspension with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to the Medical Center Director for consideration and action. The Director must make a decision within 5 working days of receipt of the recommendations. This decision could be to exonerate the practitioner and return privileges to an active status, or that there is sufficient evidence of improper professional conduct or incompetence to warrant proceeding with a reduction or revocation process.

E. If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures indicated in VHA Handbook 1100.19

must be followed. Procedures for reduction and revocation of clinical privileges are identified in the following paragraphs, and apply to all practitioners included within the scope of VHA Handbook 1100.19.

F. Adverse professional review action. Any professional review action that adversely affects the clinical privileges of a practitioner for a period longer than 30 days, including the surrender of clinical privileges or any voluntary restriction of such privileges, while the practitioner is under investigation, is reportable to the NPDB pursuant to the provisions of the VHA policy regarding NPDB reporting.

G. Procedures applicable to administrative heads. Procedures to reduce and revoke clinical privileges identified within VHA Handbook 1100.19 are applicable to Directors, COSs, Clinical Managers, and Service Chiefs. All responsibilities normally assumed by the COS during the clinical privileging reduction or revocation process will be assigned to an appropriate practitioner who serves as acting chair of the medical staff's Executive Committee. The COS may appeal the Director's decision or the Director may appeal the Associate Director's decision regarding the reduction of privileges decision to the VISN Director, just as all practitioners may appeal such a decision.

H. All administrative procedures included in this Article are processed through the Clinical Executive Board acting for the medical staff, and approved by the Director acting for the Executive Committee of the Governing Body.

Section 1. Reduction of Privileges

A. Initially, the practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff (COS). The notice will include a discussion of the reason(s) for the change. The notice should also indicate that if a reduction or revocation is affected based on the outcome of the proceedings, a report will be filed with the NPDB, with a copy to the appropriate State Licensing Boards (SLBs) in all states in which the practitioner holds a license, and in the State in which the facility is located. The notice will include a statement of the practitioner's right to be represented by an attorney or other representative of the practitioner'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 COS's written notice of intent. The practitioner must submit a response within 10 workdays of the COS's written notice. If requested by the practitioner, the COS may grant an extension for a brief period, normally not to exceed 10 workdays, except in extraordinary circumstances.

C. All information will be forwarded to the facility Director for decision. The facility Director will make, and document, a decision on the basis of the record. If the practitioner

disagrees with the facility Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 workdays after receipt of decision.

D. The facility Director will appoint a review panel of three impartial professionals, within 5 workdays after receipt of the practitioner's request for hearing, to conduct a review and hearing. At least two members of the panel will 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 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.

E. 1. The practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.

2. During such hearing, the practitioner has the right to be present throughout the evidentiary proceedings, represented by an attorney or other representative of the practitioner's choice, and to cross-examine witnesses. **NOTE:** The practitioner has the right to purchase a copy of the transcript or tape of the hearing.

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

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

H. The facility Director will 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 will indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.

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

J. The VISN Director will provide a written decision, based on the record, within 20 workdays after receipt of the practitioner's appeal. **NOTE:** The decision of the VISN Director is not subject to further appeal.

Section 2. Revocation of Privileges

A. Recommendations to revoke a practitioner's privileges must be made by the Clinical Executive Board, based upon review and deliberation of clinical performance and professional conduct information. A revocation of privileges requires removal from both employment appointment and appointment to the medical staff, unless there is a basis 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. An example could be the revocation of a surgeon's privileges for clinical practice issues, when reassignment to a non-surgical area is beneficial to meeting other needs of the facility.

B. When revocation of privileges is proposed and combined with a proposed demotion or dismissal, the due process rights of the practitioner must be accommodated by the hearing provided under the dismissal process. Where removal is proposed, the due process procedures for removal and revocation of privileges must be combined. Dismissal constitutes a revocation of privileges, whether or not there was a separate and distinct privileging action, and must be reported without further review or due process to the NPDB.

C. When revocation of privileges is proposed and not combined with a proposed demotion or dismissal, the due process procedures under reduction of privileges must pertain. In instances where revocation of privileges is proposed for permanent employees appointed under 38 U.S.C. 7401(1), the revocation proceedings will be combined with proposed action to discharge the employee under 38 U.S.C., Part V, Chapter 74, Subchapter V, or in accordance with current VA statues, regulations, and policy.

D. For probationary employees appointed under 38 U.S.C. 7401(1), the proposed revocation will be combined with probationary separation procedures contained in VA Handbook 5021. For employees appointed under 38 U.S.C. 7405, the proposed revocation will be combined with actions to separate the employee under VA Handbook 5021. Practitioners whose privileges are revoked will be reported to the NPDB according to procedures identified in the VHA policy regarding NPDB reporting.

Section 3. Independent Contractors and/or Subcontractors

A. Independent contractors and/or subcontractors acting on behalf of the West Palm Beach VA Medical Center are subject to the provisions of the facility policies on credentialing and privileging and NPDB reporting. In the following circumstances, the West Palm Beach VA Medical Center must provide the contractor and/or subcontractor with appropriate internal VA Medical Center due process, pursuant to the provisions of VHA Credentialing and Privileging policy regarding reduction and revocation of privileges, prior to reporting the contractor and/or subcontractor to the NPDB, and filing a copy of the report with the SLB(s) in the state(s) in which the contractor and/or subcontractor is licensed and in which the facility is located:

(1) Where the Medical Center terminates a contract for possible incompetence or improper professional conduct, thereby automatically revoking the medical staff appointment and associated clinical privileges of the contractor and/or subcontractor;

(2) Where the contractor and/or subcontractor terminates the contract or subcontract, thereby surrendering medical staff appointment and associated privileges, either while under investigation relating to possible incompetence or improper professional conduct; and

(3) Where the Medical Center terminates the services (and associated medical staff appointment and clinical privileges) of a subcontractor under a continuing contract for possible incompetence or improper professional conduct.

B. Where a contract naturally expires, both the medical staff appointment and associated clinical privileges of the contractor and/or subcontractor are automatically terminated. This is not reportable to the NPDB.

C. Where a contract is renewed or the period of performance extended, the contractor and/or subcontractor must be credentialed and privileged similar to the initial credentialing process, with the exception that non-time limited information, e.g., education and training, does not need to be reverified.

Section 4. Denial and Non Renewal of Clinical Privileges

A denial of initial privileges is not reportable to the NPDB. Where it is determined, for whatever reasons, that the initial application and request for clinical privileges should be denied, , the credentialing file, and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted, the Chairperson of the Professional Standards Board will promptly notify the applicant in writing. This notification will briefly state the basis for this action. “Do Not Appoint” screen must be completed in VetPro documenting the date of this decision.

A. At the time of reappraisal and renewal of clinical privileges, privileges that are denied or not renewed based on facility resources must be documented as such in the Credentialing and Privileging file, as well as the appropriate minutes. This action is not reportable to the NPDB.

B. For all other actions in which clinical privileges requested by a practitioner are denied or not renewed, the reason for denial must be documented. If the reason for denial or non-renewal is based on, and considered to be related to professional incompetence, professional misconduct, or substandard care, the action must be documented as such and is reportable to the NPDB after appropriate internal Medical Center due process procedures for reduction and revocation of privileges are provided.

Section 5. Continuing Education

The Medical Staff shall take the action to ensure effective self-governance by the following means:

A. The Professional Standards Board through the re-privileging process shall set mandatory continuing medical education goals for each health care provider and member of the Medical Staff. In no case will these requirements be less than the minimum state licensure requirements for each member of the Medical Staff who holds such a license. The Professional Standards Board may require specific continuing medical education to correct any deficiencies found through patient care assessment and performance improvement activities. This continuing education may be, at the Professional Standards Board's discretion, required of an individual practitioner, a group of practitioners (i.e., the entire service) or the entire Medical Staff.

B. Each service or discipline will have in place a mechanism to identify the important aspects of care and evaluation of the care provided. Medical staff members are expected to participate in the development of this mechanism. Recommendations and actions identified by this process shall be communicated to department or service staff at scheduled meetings or through another appropriate venue.

C. Medical Staff members are expected to adhere to all VHA regulations and all West Palm Beach VA Medical Center local policies and to conduct themselves in a professional, cooperative, and collegial manner with all individuals at all times. Intimidating and disruptive behaviors and verbal outbursts, physical threats, and refusing to perform professional duties will not be tolerated. The safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment to promote a culture of safety. (MCM 548-116)

D. Documentation of all continuing education will be maintained in the facility's Education Tracking Package and a hard copy for each medical staff member will be maintained in each of their respective provider files. This information can be used at the time of reappraisal to help document the provider's efforts to maintain professional competency. It is the obligation of the Medical Staff member to keep their service informed of the continuing education obtained by that health care provider or Medical Staff member, and to verify that this information has been accurately entered into the Education Tracking Package.

E. The biennial reappraisal process includes information concerning the individual's current licensure, health status, professional performance, judgment, and clinical/technical skill, as indicated by the results of performance improvement activities. The applicant is required to submit any reasonable evidence of current health status that may be requested by the Professional Standards Board. Reappraisal is initiated by the practitioner's Service Chief at the time of a request by the practitioner for new and renewed clinical privileges.

Section 6. Actions Against Clinical Privileges

A. When recommendations regarding clinical privileges are adverse to the applicant, including but not limited to, reduction and revocation procedures in VHA and West Palm Beach VAMC policy on credentialing and privileging will be followed.

B. Disciplinary and performance based privilege changes are undertaken after due process procedures outlined in VHA policy on credentialing and privileging and the National Practitioner Data Bank Reports, as applicable, are exhausted.

C. The Medical Center Director or their designees, may temporarily detail or reassign a practitioner to non-patient care areas of activities, thus in effect, suspending privileges while the proposed reduction of privileges or discharge, separation, or termination is pending.

(1) The facility Director, acting in the position of Governing Body as defined in the Medical Staff Bylaws, is the final authority for all privileging decisions. This decision must be based on the recommendations of the appropriate Service Chief(s), Chief of Staff, and/or Executive Committee of the Medical Staff.

(2) Furthermore, the facility 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.

D. Nothing precludes VA from terminating a practitioner in accordance with VA Handbook 5021 procedures when the separation is not for a professional reason. Health care professionals appointed under authority of 38 U.S.C. 7405 may be terminated in accordance with VA Directive and Handbook 5021, when this is determined to be in the best interests of VA.

Section 7. Reporting Adverse Actions

A. Disclosure of information to State Licensing Boards regarding VHA practitioners will be completed under VHA Handbook 1100.19

B. Disclosure of information to the National Practitioner Data Bank through State Licensing Boards regarding adverse action against clinical privileges of more than 30 days will follow provisions of VHA policy on National Practitioner Data Bank Reports.

Section 8. Reporting Malpractice Payments

Disclosure of information regarding malpractice payments determined by peer review to be related to professional incompetence or professional misconduct on the part of a practitioner will follow provisions of the VHA policy on National Practitioner Data Bank Reports (VHA Handbook 1100.17).

Note: Parameters and provisions for reporting adverse actions will be followed through the process as outlined in VHA Handbook 1100.17.

Section 9. Termination of Appointment

Termination of the Medical Staff appointments will be accomplished in conjunction with, and follow procedures for, terminating appointments of practitioners depending on the status of the medical staff member as indicated in VHA Handbook 1100.19, 38 U.S.C 7401 (1) k, (3), 38 USC 7405 VA Handbook 5021 and Directive, 38 U.S.C., Part V, Chapter 74, Subchapter V, or in accordance with current VA statutes, regulations, and policy.

ARTICLE VII. ORGANIZATION OF THE MEDICAL STAFF

Section 1. Officers

There are no officers of the Medical Staff. The Chief of Staff presides over all meetings of the Medical Staff.

Section 2. Leadership

A. The Medical Staff, through its committees, services and service chiefs, provide counsel and assistance to the Chief of Staff and Medical Center Director regarding all facets of the patient care services program, including providing leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process. Information from patient safety data is used as part of the performance improvement mechanisms, or assessments. Through the Medical Staff Committees and through the Medical Staff Professional Standards Board, the medical staff is actively involved in the measurement, assessment, and improvement of the following:

(1) Medical assessment and treatment of patients

(2) Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process

(3) Use of medications

(4) Use of blood and blood components

(5) Operative and other procedures

(6) Appropriateness of clinical practice patterns

(7) Significant departures from established patterns of clinical practice

(8) The use of developed criteria for autopsies

(9) Sentinel event data

B. All active Medical Staff members are eligible for membership on the CEB.

ARTICLE VIII. COMMITTEES

Section 1. Clinical Executive Board

The Clinical Executive Board (CEB) is the Executive Committee of the Medical Staff between the quarterly Medical Staff meetings and acts in their behalf. CEB will thoroughly review of all medical staff related activities, provide counsel and assistance to the Medical Center Director and the Executive Committee of the Governing Body regarding all facets of patient care services, continuous performance improvement goals and plans, and mission and services offered. The medical staff delegates authority to the CEB to act on its behalf in approving amendments, changes to rules, regulations, administrative policies and other activities related to the functions of performance improvement of the professional services provided by individuals with clinical privileges. The CEB will work collaboratively with other medical center leadership committees to assure that performance improvement is coordinated and integrated throughout the organization and that clinical service activities reflect the goals and priorities established in the facility's strategic plan. The CEB reports to the Executive Committee of the Governing Body (ECBG).

A. Membership of the CEB

The Chief of Staff is the Chairperson and designee of the Medical Center Director. The CEB membership includes physicians and may include other licensed independent practitioners. Permanent members include all clinical service chiefs who are active members of the medical staff. There are two (2) elected physician members at large, appointed for a term of two (2) years and chosen by a fair and equitable mechanism determined by the medical staff. Additional permanent members are defined in the MCM 548-11-123, Clinical Executive Board. The Staff Assistant to the Chief of Staff is an ex officio member of the committee.

The physician members, elected by the medical staff, may be removed by a 2/3rd vote of the voting physician members of the medical staff for failure to perform assigned responsibilities.

B. Meetings

Meetings of the CEB will be held on a monthly basis and at the call of the Chairperson when issues arise which require expediency of action. Discussion and committee action(s) via electronic means may be employed when an in-person meeting is not feasible. A quorum for the purpose of committee activities shall consist of one half of the physician voting members

C. Functional Responsibilities - The functions of the CEB are to:

(1) Act on behalf of the Medical Staff for approving amendments.

(2) Ensure effective communication between the Medical Staff and the West Palm Beach VA Medical Center Director and serves as liaison between the Medical Staff and management.

(3) Overall responsibility for recommending approval for clinical privileges and clinical scope of practice based on recommendations by the Professional Standards Boards.

(4) Make recommendations directly to the Governing Body (Medical Center Director) regarding the:

(a) Structure of Medical Staff.

(b) Mechanisms used to review credentials and delineate clinical privileges and clinical scope of practice.

(c) Recommendations of individuals for Medical Staff memberships.

(d) Recommendations for delineated clinical privileges and clinical scope of practice for each eligible individual.

(e) Organization of performance improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities.

(f) Mechanisms by which membership of the Medical Staff may be terminated which must be consistent with VA Rules and Regulations in effect at the time of the termination.

(g) Mechanisms for fair-hearing procedures, which must be consistent with VA Rules and Regulations in effect at the time of the proposed fair-hearing.

(h) Medical Staff ethics and self-governance actions.

(5) Perform annual evaluations of the Medical Staff Committee. Reviews will include findings and recommendations for coordination and facilitation of any approved, corrective actions or improvements.

(6) Receive and act on reports and recommendations from Medical Staff committees including those with quality of care responsibility, clinical services, and assigned activity groups.

(7) Receive, act on and approve criteria for granting clinical privileges and clinical scope of practice for each service.

(8) Coordinate Medical Staff activities.

(9) Receive recommendations and findings, which require approval and/or action by CEB and to ascertain whether follow-up action is required.

(10) Act independently in recommending professional policies and procedures to the Medical Center Director.

(11) Review activities to ensure compliance with all VHA and TJC requirements and recommendations, including VHA mandatory reviews of:

(a) Residents & Students who provide patient care

(b) Professional accreditation

(c) Medical records

(d) Utilization review

(e) Therapeutics agents and pharmacy reviews

(f) Medical radioisotope and radiation safety

(g) Blood services

(h) Tissue review

(i) Infection control

(j) Medical education

(k) Research and Development

(l) Medical library

(m) Emergency care

(n) Nursing home inspection

(o) Critical care units

(p) Autopsy as a percentage of deaths

(q) Geriatric program

(12) Review staffing plans and methodologies for clinical services to determine appropriate staffing levels.

(13) Reviews the clinical service contracts for patient care services when recommended by a clinical service chief or medical staff committee.

(14) The CEB, which serves as the Executive Committee of the Medical Center, may by resolution and upon approval of the Director, dissolve or rearrange committee structure, duties or composition as needed to better accomplish medical staff function.

Section 2. Patient Care Review Committee

The Patient Care Review Committee is a subcommittee of the Clinical Executive Board. It meets no less than quarterly. Special meetings may be called as determined by the chairperson of the committee.

A. Membership of the Patient Care Review Committee

(1) The Chairperson is a physician member of the Medical Staff, appointed by the Chief of Staff.

(2) The Patient Care Review Committee will be composed of interdisciplinary members as defined by MCM 548-11-299, Patient Care Review Committee (PCRC).

(a) The Patient Care Review Committee (PCRC) is an interdisciplinary monitoring committee that coordinates the service level review of high risk, high volume, or problem prone patient care activities related to the performance of operative and invasive procedures, the administration of moderate sedation, the preparation and administration of blood and blood components, and other patient care issues as commissioned by the Clinical Executive Committee.

(b) The Committee will review and trend data related to the performance of operative and invasive procedures and the administration of blood and blood components and identify stability of existing processes, opportunities for improvements in process and outcome and evaluate the results on improvement activities.

Section 3. Professional Standards Board (PSB)

The PSB meets at the request of the Chief of Staff or his/her alternate.

A. Membership of the Professional Standards Board

The Professional Standards Board (PSB) membership will be in compliance with VA Handbook 5005/17. Part II, Chap 3, Section C. The Chief of Staff shall act as Chairman. The Chief of Staff recommends appointment of the voting members to the Medical Center Director. The PSB will be composed of five voting physician members of the Clinical Executive Board and alternate members will be clinical services chief and associate service chiefs who are members of the CEB. In cases where an associate medical staff member is being reviewed for action, membership will include a minimum of two physician members and three members from appropriate peer group as appointed by the Chief of Staff. The Medical Staff Coordinator will schedule all PSB Meetings and attend as a technical advisor. A representative of the Human Resource Management Service will attend PSB Meetings as a technical advisor except when the PSB members are only discussing clinical privileges. The Health Systems Specialist/Staff Assistant for the Chief of Staff serves as an ex-officio member and subject matter expert for all Medical Staff Affairs and participants in PSB meetings. The PSB meets monthly at a minimum and at the request of the Chief of Staff.

B. Functions of the Professional Standards Board

(1) Reviews and acts on all applications for appointment and determines whether the applicant meets the requirements set forth in the VA qualifications standards.

(2) Completely reviews an individual's qualifications for advancement by examination of the official personnel folder, proficiency reports, supervisory evaluations, and other pertinent records, making recommendations to the CEB based on these findings.

(3) Conducts probationary reviews and professional competence reviews of employees who have completed their probationary period, as outlined in chapter 4 and 6 of VHA Supplement MP-5, part II.

(4) Make recommendations to the CEB on initial privileges and renewal of clinical privileges for Medical Staff members,

(5) All reviews will be conducted by the service chief recommending the proposed action. In addition, another member of the Board will review the request and supporting documentation for accuracy and appropriateness.

(6) Review the Scope of Practice of all newly appointed Nurse Practitioners or Certified Registered Nurse Anesthetists after consideration by the Nursing Professional Standards Board.

C. Included in the responsibilities of the Professional Standards Board are those responsibilities specific to individuals who are part of the facility Medical Staff as outlined for these boards in MP-5, part II, chapter 2 and VHA Supplement MP-5, part II, chapter 2.

D. Duties of the Chairperson of the Professional Standards Board will include:

(1) Make recommendations to the Medical Center Director for membership to the Nurse PSB and Licensed Practical Nurse Standards Board in consultation with the Associate Director for Patient Care Services.

(2) Make recommendations to the Medical Center Director for membership to any other PSBs deemed necessary to review and make recommendations regarding appointment or advancement, which is not within the purview of the PSB.

E. Irrespective of which board (i.e. nursing, etc.) recommends appointment or advancement, only the PSB will make recommendations to the CEB concerning initial and renewal of clinical privileges.

Section 4. Peer Review Committee

1. Peer Review Committee

A. The committee responsible for peer review, the Peer Review Committee (PRC) must be multidisciplinary, include non-physician members, and consist of senior members of key clinical disciplines. The peer review process consists of confidential critical reviews of care performed by a peer and/or group of peers. The peer review process must be in accordance with applicable laws, regulations, and current VHA policies. Peer review as designated by the Secretary of Veterans Affairs (conducted for the purpose of improving the quality of health care and/or improving the utilization of health care resources), is confidential and protected and, thus, may not be disclosed except as allowed by 38 U.S.C. 5705(b), and its implementing regulations.

B. The Chief of Staff or designee will serve as the Chairperson of the PRC. The Committee (PRC) will at minimum, consist of: The Chief of Staff, Chief of Quality Management, Risk Manager, Associate Director for Patient Care Services or designee, Surgical Physician, Internal Medicine Physician, Psychiatrist and Patient Review Coordinator. Regional Counsel may serve as advisor when needed.

C. The term “peer” is defined as an individual of similar education, training, licensure and clinical privileges or scope of practice. Persons capable of serving as a “peer” of the provider whose case is being reviewed need to be included as members of the PRC. Ad hoc members or ad hoc co-chairpersons may be added whenever appropriate.

D. The PRC will meet on a regularly scheduled basis, at least quarterly. A Chair or Co-Chair may call ad hoc meetings or add ad hoc members as needed.

E. A quorum will consist of a minimum of three (3) members, one of which must be a "peer". Physicians and the Associate Director for Patient Care Services are voting members of this committee.

F. The PRC will report at least quarterly to the Clinical Executive Board (CEB) and other disciplines as appropriate and needed.

G. Peer Review Process

(1) Cases shall be referred from various sources (e.g., Occurrence Screen Program, Patient Incident Reporting Program, Patient Representatives, patient complaints, committees, tort claims, service chiefs, or any professional working at the medical center etc.) to Quality Management. Screening for the need for protected peer review. This screening must be completed within 3 business days of identification or discovery of the event.

(2) If selected for peer review, the case is then designated as 5705 protected and all documentation will reflect as such.

(3) Peer Review Coordinator or designee will complete a clinical summary to identify provider specialty and process/system issues.

(4) Peer Review Coordinator will send letter of notification through the Chief of Staff to all appropriate Service Chiefs and the providers involved in the episode of care.

(5) Provider has three (3) administrative days to respond once letter of notification has been received from the Risk Manager.

(6) The Service Chief will notify the Risk Manager of their peer reviewer selection and after three (3) administrative days have expired, the peer review will proceed.

(7) Letter and peer review packet will be delivered to selected peer reviewer by the Patient Review Coordinator. Peer review education will be conducted prior to the peer review being performed.

(8) Peer review must be completed within 45 days of case being designated a peer review. If anticipated that a peer review cannot be completed within 45 days, a written request for an extension must be submitted to the Chief of Staff prior to the due date.

(9) There are no restrictions on multiple reviews, as long as protected and non-protected information and processes are kept separate, and as long as only the initial reporting information is forwarded from those conducting a protected review to those conducting a non-protected review.

(10) Peer review must include an evaluation of the quality of care and will be completed using the following definitions:

(a) **Level 1** – Most experienced, competent practitioners would have managed the case similarly in all of the aspects listed.

(b) **Level 2** – Most experienced, competent practitioners might have managed the case differently in one or more of the aspects listed.

(c) **Level 3** – Most experienced, competent practitioners would have managed the case differently.

(11) Returned peer reviews will be reviewed by PRC and voted upon for appropriateness of level assigned.

(12) Final review by the PRC must be completed within 120 days from the determination that a peer review is necessary.

(13) Chair of PRC will inform Medical Center Director.

(14) Chair of PRC (or designee) communicates findings of the PRC in writing to the involved providers with a copy to the Service Chief. The Service Chief is responsible to document discussion of all level 2 and level 3 findings, with actions taken, with the provider and maintain files (not identifiable by provider name) in the Service.

(15) Feedback of any action required as a result of the peer review must be accomplished by the Service Chief's (or designee) written notification to the PRC upon completion of the action.

2. **Tort claims**

Initial notification of the filing of a tort claim may generate an immediate internal protected peer review to assess the extent of clinical staff involvement, review the patient's outcome, as well as to identify, evaluate, and, where appropriate, correct circumstances having the potential to adversely affect the delivery of care**.** Regional counsel initiates an external expert opinion which is not protected.

Section 5. Physical Standards Board

This board meets on call of the Chief of Staff.

A. Membership of the Physical Standards Board

The permanent members of the Physical Standards Board are: Chief of Primary Care Service who shall serve as Chairman, Chief of the Mental Health & Behavioral Sciences, and Chief of Surgical Service. The Chief of Dentistry will attend as a member if needed. The Chief of the Human Resource Management Service (or alternate) will attend as a technical advisor.

B. The Function of the Physical Standards Board is:

(1) To determine whether VHA employees are physically or mentally fit for appointment or retention in VA employment.

(2) All board action of the Physical Standards Board shall be forwarded directly to the Professional Standards Board for recommendation to the Medical Center Director and simultaneously forwarded directly to the Executive Committee of the Governing Body of the West Palm Beach VA Medical Center.

Section 6. Executive Committee of Governing Body (ECGB)

As the top executive level management committee the ECGB assists the Medical Center Director in the execution of the leadership function of the Medical Center and provides continuity, oversight, and integration to activities involving all subordinate boards, committees, services, interdisciplinary key functions and processes involved in the operations and functions of the Medical Center.

A. Membership:

The Chairperson of the ECGB is the Medical Center Director who functions as the Chief Executive Officer and Governing Body of the Medical Center. Members of the ECGB include the chairs of the subordinate boards within the Medical Center's governance structure as well as the leaders of key clinical and administrative services and other key support and program management staff as defined in MCM 548-00-059.

B. Functions:

The ECGB will assist the Medical Center Director and provide primary oversight to the key processes included in the Medical Center's leadership function including governance, management, financial and budget control, patient safety, and compliance.

The ECFB is the terminal decision making body within the Medical Center's Governance Structure. The ECGB will review and approve all scheduled reports, selected policy revisions, mandatory reviews, annual evaluations and recommendations from subordinate Medical Center boards, committees, and services.

ECGB meets monthly at the call of the Chairperson. Minutes will be distributed to all members and maintained in the Office of the Medical Center Director.

Section 7. Standing Committees

The following is a list of the standing committees, which monitor patient care activities. Chairmanship for each committee shall be appointed by the Medical Center Director upon the recommendation of the Chief of Staff. Appointments will be reviewed every two 2) years. Membership of each committee named below is to be determined by the CEB upon recommendation of the Chairman of each committee. The function and responsibility of each committee shall be as documented in the respective Medical Center Policy Memorandum.

A. Medication Use (P&T) Committee
B. Medical Records Committee
C. Graduate Education Committee
D. Infection Control Committee
E. Critical Care Committee
F. Cardio-Pulmonary Resuscitation Committee
G. Dialysis Care Committee
H. Nutrition Committee
I. Radiation Safety Committee
J. Research and Development Committee
K. Ethics Committee
L. Continuing Medical Education Committee
M. Patient Care Review Committee
N. Medical Staff Bylaws Committee
O. Cancer Committee/Tumor Board
P. Patient Education Committee
Q. Utilization Management Committee

Minutes or an abstract of the minutes containing items requiring CEB action are to be submitted to the CEB. Frequency of committee meeting will be in accordance with the guidelines set forth in M-1, Part I. Quarterly Performance Improvement reports & an annual summary of the committee's accomplishments will be also submitted to the CEB according to a published schedule.

Section 8. Meetings

Regular meetings will be held to ensure effective communications among the Medical Staff, hospital administration, and the governing body.

A. Medical Staff Meetings

All active Staff Members shall meet at least quarterly basis for a combined meeting. This meeting shall be chaired by the Chief of Staff or his designee in his absence.

B. Service Meetings

Each Service shall hold regular meetings, as often as necessary, but no less than quarterly, to review and evaluate the clinical and administrative work within their Services. The evaluation should consist of, but not limited to, utilization of resources, performance improvement and risk management, productivity, and standards set forth by the TJC in the applicable accreditation manuals.

C. Special Meetings

The Medical Center Director or the Chief of Staff may call a special meeting of any service or any committee at any time when he or she determines the quality of health care necessitates the need for such a meeting.

D. Meetings of the CEB

Meetings of the CEB will be held at least every other month and at the call of the Chairperson when issues of medical staff appointment or reappointment require expediency of action. Discussion and committee action(s) via electronic means may be employed when an in-person meeting is not feasible.

Section 9. Attendance and Quorum

A. Attendance

(1) Attendance by members of the (active) Medical Staff at scheduled staff meetings is mandatory unless the Chairperson approves the absence. If the chairperson is unable to attend, he or she must designate another physician to serve as chair.

(2) Attendance is mandatory for all other Committee or Service meetings unless the Chairperson approves the absence.

B. Quorum

(1) A quorum, for purposes of Medical Staff meetings, is defined as 40% of the active membership.

(2) A quorum for all other committees or Services, unless otherwise designated, is defined as 50% of the members present.

A quorum for the CEB is defined as 50% of the physician voting members.

Section 10. Meeting Minutes

A. Minutes of all meetings will reflect, at a minimum, attendees, absentees, those excused, issues discussed, conclusions, actions, recommendations, evaluation and follow up. These minutes are to be forwarded to the appropriate reviewing body within 30 days of the meeting.

B. The minutes shall be approved by a majority of the members present and shall be signed by the Chairperson and copies provided to all appropriate individuals.

C. Format and distribution of all reports and minutes will be in accordance with Medical Center Policy Memoranda

ARTICLE IX. CLINICAL SERVICES

Section 1. Characteristics

A. Clinical Care Services - Each Service shall be organized as a division of the Medical Staff and shall have a Chief who shall be according to VA regulations responsible for the overall supervision of the clinical work within the service. The structure will allow for the integration of caregivers into multidisciplinary health care teams, which provide optimal care across the continuum of services. Specific patient care services will be determined by the Medical Center Director upon the recommendations of the CEB and Strategic Planning Board (SPB). An organizational chart of the West Palm Beach VA Medical Center is included as Attachment A to these Bylaws. New patient services may be established when authorized and directed by the Medical Center Director. The Governing Body is ultimately accountable for the safety, quality and care of treatment.

B. Meetings should meet the requirements described in Article VIII, Section 8 of this document.

C. Assignment - Each health care provider will be assigned to a patient care service depending upon the individual's qualifications and the needs of the medical center as determined by the Medical Center Director.

Section 2. Selection and Appointment of Service Chiefs

Service Chiefs are appointed by the Medical Center Director based upon the recommendation of the Chief of Staff, in accordance with criteria set forth in VHA Directive 5111. Physician Service Chiefs must be certified by an appropriate specialty board or possess comparable competence. Appointment of service chiefs without board certification must comply with VHA Handbook 1100.19 and the VHA policy for these appointments as appropriate.

Section 3. Duties and Responsibilities of Service Chiefs

Each Clinical Service Chief shall be responsible to the Chief of Staff to provide effective leadership for the activities falling within his or her responsibility. Each Clinical Service Chief is responsible for the following:

A. All clinically related activities of the service.

B. All administrative activities of the service unless otherwise provided for by the facility.

C. The integration of the service into the primary functions of the organization and the integration service mission and goals into those of the medical center and the Department of Veterans Affairs.

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

E. The development and implementation of policies and procedures that guide and support the provision of services.

F. The identification of and recommendation for the sufficient number of qualified and competent persons to provide care and services.

G. Continuing surveillance of the professional performance of all individuals who have delineated privileges or defined scopes of practice in their services.

H. Recommend to the Professional Standards Board (PSB) the criteria for clinical privileges in their services and ensuring appropriate resources are available for each privilege.

I. Recommending what clinical privileges should be granted to members of their service.

J. The determinations of the qualifications and competencies that service personnel who are not licensed independent practitioners possess which allow them to provide patient care services. These qualifications and competencies will be judged and documented through the use of a scope of practice statement or other process approved by the Medical Center Director in compliance with VHA regulation.

K. The continuous assessment and improvement of the quality of services provided. These assessments may be performed through the Performance Improvement Plan or by other mechanisms identified by the facility leadership.

L. The maintenance of quality control programs, as appropriate.

M. Orientation, participation and continuing education with documentation of all persons in his or her service.

N. Recommendations for space and other resources needed by the service to provide safe, efficient, and quality care.

O. The Service Chief assesses and recommends to the Medical Center Director, through the relevant medical center authority, off site sources for needed patient care, treatment, and services which cannot be provided by the service or the organization.

ARTICLE X. PERFORMANCE IMPROVEMENT PROGRAMS

There will be an on-going Performance Improvement Program that includes a systematic and on-going mechanism for reviewing and evaluating patient care as well as an appropriate response to findings. A plan for assuring the comprehensives and integration of the overall Performance Improvement Program is described in West Palm Beach VA Medical Center MCM 548-99-162 "Organizational Performance Improvement Plan".

ARTICLE XI. RULES

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically, the general principles found within these Bylaws and guidelines of the Governing Body, subject to the approval of the Medical Center Director. These rule and regulations shall not conflict with the requirements of the Federal or State law, VA Rules or Regulations.

1. These rules and regulations may be changed by 50% of the voting members of the Medical Staff present at a meeting and 2/3rd vote of the quorum. Any member of the Active Medical Staff may submit a proposed change to the Bylaws Committee, which will in turn submit this change to the CEB for information. The Chairperson for the Bylaws Committee will submit the proposed revision for vote at the next meeting of the Medical Staff. A majority vote of the members present is necessary for passage of changes in the rules. Such changes shall only become effective when approved by the Medical Center Director.

2. Written text of the proposed changes will be provided to Medical Staff members with voting privileges. They will be given at least ten (10) business days to review the proposed changes and be notified of the date proposed changes will be considered.

3. In case of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Chief of Staff may convene an urgent Medical Staff meeting. Urgent amendment requires 50% of the voting members of the Medical Staff present and a 2/3rd vote of the quorum.

ARTICLE XII. AMENDMENTS

The bylaws and rules are reviewed by the Medical Staff at least every two (2) years by the Bylaws Committee, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Neither the Medical Staff nor the governing body of the West Palm Beach VA Medical Center may unilaterally amend the medical staff bylaws or rules and regulations. In addition, at any time, any member of the Medical Staff may submit a proposed change to the Bylaws Committee, which will in turn, communicate this change to the CEB for review. Changes to the bylaws are amended, adopted and voted by the Organized Medical Staff as a whole and then approved by the Director. Bylaws changes require 50% of the voting members of the Medical Staff present for passage at a regular or special meeting of the Medical Staff which may convene in person or via electronic communication. A 2/3 vote of the quorum is required for passage of changes.

All changes to the Bylaws require action by both the Organized Medical Staff and the Medical Center Director. Written text of the proposed changes to the Bylaws are to be provided to Medical Staff members with voting privileges. Medical Staff members will be given ten business days to review the proposed changes and be notified of the date the proposed changes will be considered. Such changes shall only become effective when approved by the Medical Center Director.

ARTICLE XIII. ADOPTION

These Bylaws, together with the appended Rules, shall be adopted upon recommendation of the Organized Medical Staff, and shall become effective when approved by the Medical Center Director.

ADOPTED BY THE MEDICAL STAFF OF THE WEST PALM BEACH VA MEDICAL CENTER ON APRIL 23, 2015.

RECOMMENDED BY:

_____ _____/_____/_____

Deepak Mandi, MD
Chief of Staff **Date**

APPROVED BY:

_____ _____/_____/_____

Charleen R. Szabo, FACHE **Date**
Medical Center Director

RULES AND REGULATIONS
OF THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
WEST PALM BEACH, FLORIDA

1. GENERAL

The Rules and Regulations specifically relate to roles and/or responsibilities of the members of the Medical Staff and other individuals with Clinical Privileges for patients receiving emergency, ambulatory, acute, extended or community care. Rules and Regulations are applicable to the entire Medical Staff and do not conflict with Medical Staff Bylaws and policies of the Medical Center, or requirements of the Governing Body.

2. PATIENTS' RIGHTS AND RESPONSIBILITIES

A. Explanation of Patients' Rights

Patients' rights and responsibilities will be explained by staff in a manner that is understandable to the patient and/or family. This includes the use of an interpreter when needed. Patient rights and responsibilities apply to patients who are legally competent with intact decision making capacity. When the patient is legally incompetent or lacks intact decision-making capability, these rights can be exercised on the patient's behalf by a designated surrogate or proxy decision-maker.

B. Employee Responsibility for Patients' Rights

All employees are responsible for respecting patients' rights. Staff is required to comply with MCM 548-136-078 "Patients' Rights and Responsibilities."

3. INFORMED CONSENT

A. Patients' Right to Informed Consent

The Department of Veterans Affairs is committed to providing a health care environment that recognizes the patient's right to self-determination. Patients may accept or refuse any treatment offered to them. Except as otherwise provided in policy, diagnostic and therapeutic procedures or treatments must be undertaken only with prior, informed consent of the patient or the patient's surrogate decision-maker. The physician, dentist, or other authorized practitioner must ensure the patient (or where appropriate, the patient's representative) understands the name, nature and details of a proposed diagnostic/therapeutic procedure or course of treatment, the indications, expected benefits, associated risks, complications or side effects, reasonable and available alternatives and anticipated results if nothing is done. The patient must be allowed to ask questions and to make a decision freely and without coercion or duress. The consent process is completed once appropriately documented in the patient's medical record.

B. Staff Responsibility regarding Informed Consent

Staff is required to comply with specifics as outlined by the MCM 548-99-115 **"**Informed Consent."

4. GENERAL RESPONSIBILITY FOR CARE

A. Conduct of Care

(1) Management of the patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff. All non-physician practitioners will have a designated preceptor or supervising physician to assure that each patient has a designated physician responsible for their care.

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

(3) Patients with the same health status and conditions will receive a comparable level of quality care throughout the Medical Center.

(4) There is coordination of care, treatment and services among all the practitioners involved in a patient's care, treatment and services.

B. Emergency Services

(1) Emergency services are provided 24 hours each day, 7 days each week by appropriately credentialed and privileged providers. Specialists are available by consultation through an on call schedule made available by each of the consulting services.

(2) Essential life-saving measures and emergency procedures will be instituted to minimize further compromise to any patient who presents in need of emergency care including any infant, child or non-veteran adult.

(3) Specifics on services provided and admission guidelines can be found in MCM 548-110-071 "Emergency Department."

(4) There will be mass casualty assignments for providers and dentists as contained in the Medical Center Emergency Preparedness Plan. Copies of this plan can be found in every service and on Forms Navigator. It is the responsibility of the providers to know their responsibilities and to report to their assigned stations when needed.

C. Admissions

(1) Qualified physician or oral-maxillofacial surgeon members of the Medical Staff are granted specific privileges to admit patients for care. The patient's primary care provider will be notified of the admission.

(2) All admissions at the West Palm Beach VA Medical Center will be reviewed against InterQual criteria. Prior to admitting a patient or accepting a patient in transfer, providers must contact Utilization Management (UM) and provide clinical information including examinations performed, results of diagnostic studies and the tentative plan of care. The UM nurse will inform the provider if the patients' care needs do meet the intensity of service or severity of illness criteria. Alternative to inpatient admission may be offered. The final decision always rests with the provider. Admissions that do not meet criteria will be referred to the Utilization Management Committee as a performance measure.

(3) Except for emergencies, no patient shall be admitted without a provisional diagnosis or other valid reason for admission documented in the medical record.

(4) That portion of the history and physical examination relating to dental, podiatric or optometric care shall be completed by the dentist, podiatrist, or optometrist, as the case may be. Some dentists, because of their training and experience, may be privileged to perform the full history and physical. Dentists possessing such credentials must request and be granted full H&P privileges before performing them without countersignature.

(5) Physician Assistants and Advance Practice Nurses may perform History and Physical under the supervision of a License Independent Practitioner (LIP).

D. Inpatient Care

Inpatients are assigned to the care of a member of the Medical Staff with clinical privileges who is responsible for:

(1) The medical care and treatment of each patient for any medical problem that may be present on admission or that may arise during hospitalization.

(2) Prompt completion and accuracy of the medical record.

(3) Participating in the development of an interdisciplinary care plan for the patient.

(4) Ordering appropriate laboratory and imaging examination guided by the patient's medical history and clinical findings.

E. Special Care Units (Intensive Care Units)

(1) Admission to the intensive care units will be based upon the established admission criteria and will be approved by the intensivist on duty. Specifics on services provided can be found policies: MCM 548-111-76 “Admission and Discharge Criteria for Intensive Care Units” and MCM 548-111-100 “Intensive Care Units.”

(2) When need for ICU beds exceeds availability, the intensivist in charge will decide which patient(s) will be considered for discharge from the ICU and which patient(s) will receive priority for ICU admission.

F. Transfers

The decision to transfer a patient is to be based on the level of care needed. The decision to transfer a patient will not be based on financial concerns.

(1) For transfers to facilities outside the West Palm Beach VAMC, MCM 548-11-141 “Inter-facility Admission and Transfers” is followed.

(2) For transfers within the West Palm Beach VAMC, MCM 548-11-199 “Admission, Transfer and Discharge” is followed.

(3) Need to use the Transfer Note/Handoff Communications

G. Consultations

(1) Consultations will be performed by a qualified practitioner with clinical privileges or scope of practice within his/her area of expertise in accordance with MCM 548-11-359 “Consultations.”

(2) A satisfactory consultation should include physical examination of the patient, review of all pertinent data relating to the patient such as x-rays and laboratory studies, and review of the patient’s previous medical records as appropriate to answer the question posed in the consultation. A written opinion signed by the consultant must be included in the medical record.

(3) Except in a life-threatening emergency, consultation with another qualified physician/dentist is required prior to initiation of treatment when, in the judgment of the patient’s physician, the risk factors may be life threatening or obscure the diagnosis or the best therapeutic approach.

(4) Time limits for the completion of consultations are dependent upon the clinical situation:

(a) A list of the available categories of consults is contained in the consult ordering component of the Electronic Medical Record.

(b) Surgery consultations: Prior to the scheduled surgery except in the case of an emergency.

(c) Psychiatric consultations: Consultation with a qualified psychiatrist will be requested for all patients who have threatened or attempted suicide or have taken a chemical overdose. This consultation and the recommended treatment, is applicable, will be documented in the medical record.

(5) Cancellation (denial) of a consult is justified when diagnostic or therapeutic recommendations are provided to the requestor without the patient needing to be seen by the consultant or when the consulting service needs additional information before seeing the patient. Consultations cancelled (denied) by the consulting service will provide the reasons for this action support staff will deny consults only according to criteria established by the service or section chief. The requestor may then resubmit the consult with the additional information or after the recommendations of the consulting service have been considered.

(6) The roster of on call specialists will be available to all employees at all times. This will be accomplished through both electronic access to the roster and printed copies posted in appropriate locations.

H. Discharge

(1) Discharge planning is an ongoing, interdisciplinary process beginning prior to admissions for scheduled admissions and at the time of admission for unscheduled (emergent) admissions. Staff is expected to adhere to requirements found in MCM 548-11-199 "Admission, Transfer and Discharge."

(2) Discharge planning is ongoing and arrangements for patient discharge will be completed and clearly documented as part of the admission process as soon as the patient's needs are identified.

(3) Responsibility for discharge from a special care unit is based on discharge criteria including priority determinations as outlined in MCM 548-111-76 "Admission and Discharge Criteria for Intensive Care Units."

(4) Discharge from the post anesthesia care unit (PACU) is upon the order of a licensed independent practitioner or by Medical Staff approved criteria in accordance with MCM 548-112-268 "Admission and Discharge Criteria PACU."

I. Autopsy

(1) In the interest of improving patient care and professional knowledge, Medical Staff are expected to actively participate in obtaining authorization for autopsies on all deaths, taking into account any known religious or cultural considerations prior to seeking consent.

(2) Staff is expected to comply with requirements of MCM 548-113-079 "Autopsy Policy."

J. Organ Donation

Members of the Medical Staff of West Palm Beach VA Medical Center will support the voluntary donation of organs and tissues by assessing all patients at or near the time of death for medical suitability of organ/tissue donation in accordance with the Florida State Statues 765.510 and 765.522 and with MCM 548-118-119 "Organ Donations."

K. Submission of Surgical Specimens

All tissues and objects except teeth removed at operation shall be sent to the Facility pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

L. Special Treatment Procedures

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

(a) Physicians, nurses and other members of the treatment team are responsible for the proper documentation of the code status as well as for the comfort and maintenance of dignity of their patients who have an order to forego cardiopulmonary resuscitation.

(b) Staff physicians are responsible for ensuring that appropriate documentation supporting their diagnosis is available in the patient's electronic medical record. They must document their discussions regarding resuscitation with the patient or the patient's surrogate, as well as the agreement of the patient or their surrogate with the code status order. The physician is responsible for ensuring that the order is renewed as defined in MCM 548-11-338 "Code Status."

(2) Restraint and Seclusion.

This Medical Center has established a patient-focused process for the implementation, application and documentation of physical restraints and seclusion. The intent of this policy is to ensure that

any use of restraint or seclusion protects and preserves the patient and his/her rights, dignity and wellbeing. Staff is required to comply with all aspects of MCM 548-118-409 "Use of Physical Restraint During Acute Medical-Surgical Care," and MCM 548-118-410 "Use of Physical Restraint and Seclusions for Behavioral Health Reasons."

5. PATIENT ORDERS

A. Patient Care Orders

Staff is required to comply with all requirements contained in MCM 548-11-357 "Patient Care Orders."

B. Origination of Orders

Orders may be originated by providers authorized to do so, in accordance with the parameters outlined within their approved clinical privileges and/or scope of practice.

C. Orders in the Electronic Medical Record

All patient care orders will be entered in the Electronic Medical Record (EMR) and will be signed by the provider originating the order. Exception: controlled substance orders entered by Advance Practice Nurses or Physician Assistants must be signed by their supervising/collaborating physicians. No hand written orders will be accepted or maintained except for outpatient Schedule II controlled substance prescriptions and as a contingency in the event of a Code Purple (computer failure/downtime).

D. Electronic Signature of Orders in the EMR

Providers will enter their orders in the EMR and they will be authenticated via the provider's electronic signature. In the outpatient setting, orders may be indicated in the authenticated progress note for the visit.

E. Orders for Medications

All medication/IV orders written on all medical center patients will conform to the parameters contained within the pertinent medical center policies and the Drug Formulary.

F. Verbal and Telephone Orders

Verbal or telephone orders will not be used routinely and will be used when action is required immediately and the provider is unable to enter his/her own orders. Only a registered nurse, a registered pharmacist or a respiratory therapist may receive verbal orders. The person receiving the telephone or verbal orders will read back the order to verify correctness of order. Do not resuscitate (DNR), Chemotherapy, or Total Parenteral Nutrition (TPN) orders will not be issued

as verbal or telephone orders and require direct order entry by the provider. Verbal and telephone orders will be signed within72 hours.

6. SUPERVISORY RESPONSIBILITIES OF THE MEDICAL STAFF

Supervision of Residents, Students, and Allied Health Professionals

A. Mechanisms by which residents or students are supervised by appropriate attending staff in carrying out their patient care responsibilities are outlined in affiliation agreement in accord with MCM 548-142-396 "Monitoring of Resident Supervision," MCM 548-142-395 "Supervision of Medical Students," and MCM 548-142-368 "Affiliations Review Committee."

B. MCM 548-11-357 "Patient Care Orders" specifies who may write patient care orders, the method of supervision, and the exceptions. These policies will not prohibit a member of the Medical Staff from writing orders for a resident or student.

C. Each service will outline the mechanisms by which non-physician practitioners (e.g., CRNAs, PAs, NPs, etc.) are supervised by the Medical Staff. These mechanisms will be in compliance with VA regulation on supervision of non-physician practitioners.

D. Each service will establish guidelines to assure that there is sufficient evidence documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending staff. The level of supervision shall be determined by the nature of the patient's condition, the likelihood of changes in the treatment plan, the complexity of the care and scope of practice of the person being supervised. At minimum, the attending staff will appropriately document the patient's medical record within 24 hours of admission for acute care and 72 hours for extended care, at the time of any significant change in the clinical course or therapeutic plan, within 24 hours of discharge, or prior to any invasive procedure.

7. MEDICAL RECORDS

A. Ownership

All records and the printed copies of electronic patient records are the property of the Department of Veterans Affairs and shall not be released from the DVA except for the purposes of responding to an order from a court of competent jurisdiction or in accordance with VA Regulations and HIPAA. Medical information required for statistical or research purposes will not include patient's name, social security number, or any other identifiable data in accordance with 38CFR 16.101(b) and HIPAA. In case of readmission of a patient, all previous records on file shall be available for use of the physician/dentist. Records may only be released by individuals authorized by the Chief, Medical Administration Service to release those records.

B. Responsible Staff Unavailable

If a staff member becomes deceased or unavailable permanently or protractedly for other reasons, those medical records for which he/she was responsible will be reviewed by the responsible Service Chief and presented to Medical Records Committee. The service chief shall make an entry into the patient's medical record stating the reason it is incomplete. The CEB may declare a record complete for the purposes of filing based on the recommendation of the Medical Record Committee (MRC) and will bear a notation stating the circumstances under which it is being filed.

C. Documentation of Supervision

There shall be sufficient evidence as documented in the medical record to substantiate active participation in and supervision of the patients care by the attending/primary care physician.

1. Admission and preoperative history and physical exams by students will be repeated by the resident and mid-level practitioner or attending physician and documented in a separate note

2. Attending physician co-signature of the following is required to document supervision:

a) Admission and preoperative history and physical examination performed by any mid-level practitioner or resident;

b) Discharge summaries and discharge notes by anyone other than the attending physician

c) Operative notes, including brief op notes and

d) Death notes

3. Supervising practitioner or the attending physician will cosign all progress notes by students

D. Basic Administrative Requirements

(1) All entries made to the medical record will be legible, intelligible, dated, and authenticated (with method to identify author) by written or electronic signature.

(2) Authenticated electronic signatures will be used in compliance with MCM 548-711-002 "Automated Information Systems Security Policy."

(3) Use of Approved Abbreviations and Symbols

(a) Medical abbreviations and symbols shall be restricted to those approved by Medical Records Committee and outlined in MCM 548-136-118 “Use of Symbols and Abbreviations in Medical Records.”

(b) Medical abbreviations and symbols strictly prohibited from use by the Medical Records Committee are listed in MCM 548-136-118 “Use of Symbols and Abbreviations in Medical Records.”

(4) Release of information - The Privacy Act of 1974, 5 U.S.C. 552a, and the Health Insurance Portability and Accountability Act (HIPAA) assures that personal information about individuals collected by Federal agencies is limited to that which is legally authorized and necessary and is maintained in a manner which precludes unwarranted intrusion upon individual privacy. All disclosures will be disseminated in accordance with the Privacy Act of 1974, 5 U.S.C. 552, and VA regulations. The individual about whom such information concerns, may ascertain what records are collected, maintained, used or disseminated. He or she may review these records, request corrections or amendments, and may have copies made. All persons with access to confidential information protected by the Privacy Act of 1974 are responsible for safeguarding this information from unauthorized disclosure. Staffs are expected to comply with MCM 548-136H-092 “Release of Medical Information.”

E. Basic Patient Information Requirements for the Medical Record

Basic patient information requirements for the medical record are:

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

(2) Personal history, family history, occupational history, military history and medical history, including, history and details of present injury, allergies/ADR (Adverse Drug Reaction) and medication list.

(3) Physical examination.

(4) Observations, including results of therapy.

(5) Diagnostic and therapeutic orders.

(6) Reports of procedures, tests and their results.

(7) Progress notes including condition on discharge (discharge summary or note).

(8) Operative report including pathological findings.

(9) Consultation reports.

(10) Conclusions at termination of hospitalization, or evaluation/treatment.

(11) Informed consent before procedures or treatments undertaken and if not obtainable, the reason.

F. Inpatient Medical Records

In addition to the information described in section 4E above, the inpatient record will include the following documentation by the attending staff:

(1) History that includes relevant past, social, family, military and occupational history, and an inventory of body systems completed and authenticated within 24 hours of admission to acute care and within 48 hours of admission to the Community Living Center.

(2) Progress Notes - pertinent progress notes shall be recorded at the time of observation with sufficient content to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress note and correlated with specific orders as well as results of tests and treatments.

(a) A progress note shall be written before and after each operative or invasive diagnostic procedure, giving pre-operative condition of the patient, nature of pathology identified, descriptive recording of procedure performed, specimen removed, if any, and the post operative condition.

1. Pre and post anesthetic care
2. Initiation of a change in resuscitation status or of advance directives
3. Documentation of the Consent process using IMED consent whenever possible and available
4. Episodes of seclusion or restraints
5. Transfer between services or level of care
6. Invasive radiology procedure
7. Patient who leaves Against Medical Advice (AMA) as describe in MCM 548-11-199, “Admission, Transfers and Discharges”
8. Discharge
9. Death

(b) Whenever possible, every inpatient in an acute care bed will be visited at least once each calendar day and a progress note written by the attending physician or a designated nurse practitioner and or physician assistants.

(c) Progress notes on patients considered long term care shall be written at least monthly for the first 90 days after admission, at least every 60 days thereafter up to one (1) year and then at least every 90 days. If there is difficulty with diagnosis, management where the illness becomes unstable, or a new medical problem occurs in which case a progress note will be written daily until the condition is stabilized.

(d) Progress notes shall be written at least twice weekly on patients considered sub-acute care unless there is difficulty with diagnosis, management where the illness becomes unstable or a new medical problem occurs at which case daily progress notes shall be written. The requirement for progress notes may be satisfied by either the nurse practitioner or the collaborative physician.

(e) Progress notes shall be written immediately prior to all invasive procedures. The operating physician/oral-maxillofacial surgeon will perform a clinical assessment of the patient to determine that the diagnostic or therapeutic plan remains consistent with the patient's current status and documents that plan for conscious sedation remains the same.

(f) Transfer Documentation: A discharge summary is required if patient is transferred from inpatient setting to outpatient setting or from inpatient setting to a different facility. i.e. Community Living Center to another facility (VA to VA , VA to private facility /Nursing Home). This must be entered prior to transfer of the patient.

(3) Physical Examination

(a) Physical Examination will be performed, completed and authenticated within 24 hours of acute or sub-acute admission and within 48 hours for the Community Living Center.

(b) Exceptions to the 24-hour time limit are:

1. When, within a 30-day period for admission to acute care or within 5 days for admission to extended care, a patient is readmitted for the same or different condition, the previous history and physical examination with an interval progress note will suffice. The interval progress note entered by the physician or dentist will contain a statement that the previous history and physical examination of has been reviewed, and a statement of the pertinent addition to the history and/or subsequent changes in the physical findings as specified, or a statement indicating there is no change noted in the review of the previous history and physical examination.

2. For patient stays that are anticipated to be less than forty eight (48) hours, the History and Physical examination may be focused on the patient's main complaint for the hospital stay, when, in the judgment of the physician, it will provide adequate data. If the length of stay exceeds the projected forty eight (48) hours, a more comprehensive

history and physical will be required to be performed by the attending physician. Addendum of the focused H&P to include all required components of a full H&P is permissible.

(c) If an inpatient is hospitalized for greater than 365 days, he/she shall have an annual physical examination, which will be documented in the medical record.

(d) Physical Examination will be performed prior to surgery.

(e) Physical Examination will be authenticated by physician/dentist. Each entry in the medical record shall be dated and authenticated by the signature of the physician/dentist or other responsible member of the medical care team making the entry.

(f) Physical examinations findings will contain conclusions or impressions drawn from history and physical examination, a tentative working diagnosis, and a planned course of action.

(4) Condition on discharge

(a) Discharge Orders will be written by a physician or oral-maxillofacial surgeon member of the Medical Staff prior to discharge.

(b) Discharge summaries should be dictated within 24 hours after the patient's discharge. Dictated discharge summaries should be signed as soon as they are available after transcription. Discharge summaries for acute care patients will be considered delinquent if not available in the medical record within 7 days of discharge.

1. The discharge summary will concisely summarize the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, ,discharge diagnosis, the patient's condition on discharge, discharge medications, plan for follow-up, VA competency and any specific instructions given to the patient and/or family, as pertinent.

2. An interim discharge summary indicating the patient's hospital course to that time is done by the attending physician when the patient is transferred to a different level of hospitalization or residential care within the organization. A final discharge summary is done by the physician in charge of the patient's care when the patient is discharged from inpatient care.

3. For admissions of less than forty eight (48) hours, a discharge progress note, containing all pertinent information, will suffice. Further references to the discharge summary are included in MCM 548-11-199 "Admission, Transfer and Discharge."

4. A final progress note is substituted for a discharge summary for patients who leave inpatient care against medical advice (AMA) or are absent

without leave (AWOL). In these cases, the final progress note written and recorded in the medical record must include any information known of the reason for the patient's wishes to leave against medical advice or any measures taken to prevent elopement.

5. All charts are to be complete as to all documentation requirements within 7 days of discharge with the exception of the Community Living Center, which will be completed within 21 days.

(5) Death and Autopsy Documentation:

(a) Death note the pronouncing physician will document a progress note at the time of death. When appropriate will include request for consent to perform an autopsy from the legal next of kin, and document whether consent was granted or not. If consent is not sought the reason will be documented as well.

(b) The attending physician is responsible for completing a discharge summary on all expired patients

G. Outpatient and Emergency Area Medical Record

(1) A pertinent progress note is required by the provider at the time of outpatient encounter and will be sufficient to promote continuity of care and transferability.

(2) A relevant history of illness or injury and physical findings including vital signs shall be recorded. Upon first entry for VA Ambulatory Care, initial evaluation shall contain a History and Physical Examination as required for management of the patient's problem(s) for which he/she is seeking help.

(3) All outpatient records whether emergency or not, will contain a diagnosis impression as well as a treatment plan. A vague diagnosis such as "no change" is not acceptable. Instructions given to the patient and plan for follow-up care will be documented.

(4) Immunization status will be recorded as appropriate.

(5) Referrals and communications with and to other providers and hospitals whether VA or non-VA.

(6) A list of significant diagnoses, conditions, procedures, drug allergies, medications and problems diagnosed or performed anywhere will be initiated by the time of the patient's third outpatient encounter and updated as necessary upon subsequent encounters for outpatient care and recorded as a Summary List.

(7) The Problem List is maintained by the all providers.

(8) Operative or invasive procedures performed on an ambulatory basis whether in the operating room or not will be documented in an Operative Report or in an Invasive Procedures Template. In addition, explicit reference to the procedure and a summary of its outcome will be provided in the patient's Progress Notes. Other pertinent requirements can be found in MCM 548-112-160 “Operative and Invasive Procedures.”

(9) Specific requirements for records of patients treated in the evaluation center include time and means of arrival, care received prior to arrival, conclusions at termination of treatment including final disposition, condition at discharge, and any instructions for follow-up care. In cases where patients leave Against Medical Advice (AMA), there must be a progress note written and signed by a Medical Staff member. Other pertinent requirements can be found in MCM 548-110-071 “Emergency Department.”

(10) Patients who are carried in an observation status will have a focused assessment performed by the physician. The patient will be reevaluated within at least 23 hours to determine the need for admission or release. If the patient is admitted, the focused assessment must be amended to include all required components of an admission History and Physical examination.

H. Operating Room Record

(1) The surgeon will record and authenticate a pre-operative history and physical (including a diagnosis) and a reassessment immediately prior to the procedure in the medical record before surgery. When a history and physical examination are not recorded before the time stated for elective operation, the operation will be canceled. In emergency situations when delay would constitute a hazard to the patient and transcription of the history and physical examination is not possible, suitable data will be recorded in the chart in the form of pre-operative progress note written by the operating surgeon.

(2) The Anesthetist shall maintain a complete anesthesia record to include evidence of evaluation immediately prior to induction and post-anesthesia follow-up of the patient's condition.

(3) Intra-operative documentation shall contain both descriptions of the procedure, findings and a detailed account of techniques used and tissues removed. All operations performed by the operating surgeon shall be described fully.

(4) Evaluation of postoperative status on admission to and discharge from post-anesthesia recovery and any orders required for discharge.

(5) Operative reports are dictated or entered in the medical record **IMMEDIATELY** after surgery. Any procedure requiring any type of anesthetic agent or conscious sedation requires such a report. Operative reports are dictated or entered in the medical

record immediately after surgery and describe the findings, the technical procedures used, the specimen(s) removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants. When the operative report is not placed in the medical record immediately after surgery (for example, there is a transcription and/or filing delay), an operative progress note is entered in the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient.

(6) Documentation requirements associated with the use of moderate sedation can be found in MCM 548-112-298 "Guidelines for Use of Moderate Sedation."

(7) Postoperative documentation will include, at minimum, a record of vital signs and level of consciousness at admission and during stay in Post anesthesia Recovery Unit (PACU) or other approved recovery area, any medications (including intravenous fluids) and blood and blood components given, any unusual events recorded intra-operatively and any postoperative complications, including blood transfusion reactions and the management of those events.

8. INFECTION CONTROL

A. Policy

It is the policy of this medical center to provide mechanisms for the prevention, data collection, and control of hospital and community acquired infections through continuous surveillance, education, and intervention.

B. Staff Compliance with Policy

Specific Medical Center Memoranda address individual aspects of the Infection Control program including but not limited to the following:

Infection Control	MCM 548-118-216
Medical Center Infection Prevention Committee	MCM548-111-185
Hand Hygiene	MCM 548-118-134
Bloodborne Pathogens Exposure Control Plan	MCM 548-111-261
Tuberculosis Control Plan	MCM 548-111-240
Occupational Health Program	MCM 548-111-132
Isolation and Precautions for Infection Control	MCM 548-118-262
Disease Reporting to the Palm Beach County Health Department	MCM 548-118-265

Staff is expected to comply with requirements in these policies as they apply to their employment and practice.

C. Screening for Tuberculosis

All employees, including transfers from other VA facilities, must be screened for tuberculosis (TB) upon hire and annually thereafter. Employees have the right to refuse testing but must do so upon reporting to Occupational Health.

9. DISASTERS

The Medical Center has an Emergency Preparedness Plan that is available and distributed throughout the Medical Center. Staff responsibilities in local disasters or national disasters or in the facility's role in the VA/DOD Contingency Plan are outlined the Medical Center Emergency Preparedness Plan.

10. IMPAIRED PROFESSIONAL PROGRAM

Responsibility to the impaired professional is recognized by our Medical Staff and can be addressed through the Professional Health and Effectiveness Program of the appropriate State Licensing Board(s) in addition to resources delineated in current facility policy on impaired professionals. This program is outlined in the MCM 548-11-404 “Health Status of Medical/Dental Staff”

11. MEDICAL CENTER MEMORANDA

Medical Center memoranda are considered an extension of the Rules. They are available to all staff directly through the WPB SharePoint. They are available to prospective staff for review upon request.

ADOPTED BY THE MEDICAL STAFF: APRIL 23, 2015

APPROVED: _____ **4/24/2015**
Deepak Mandi, M.D. **Date**
Chief of Staff

_____ **4/24/2015**
Charleen R. Szabo, FACHE **Date**
Medical Center Director