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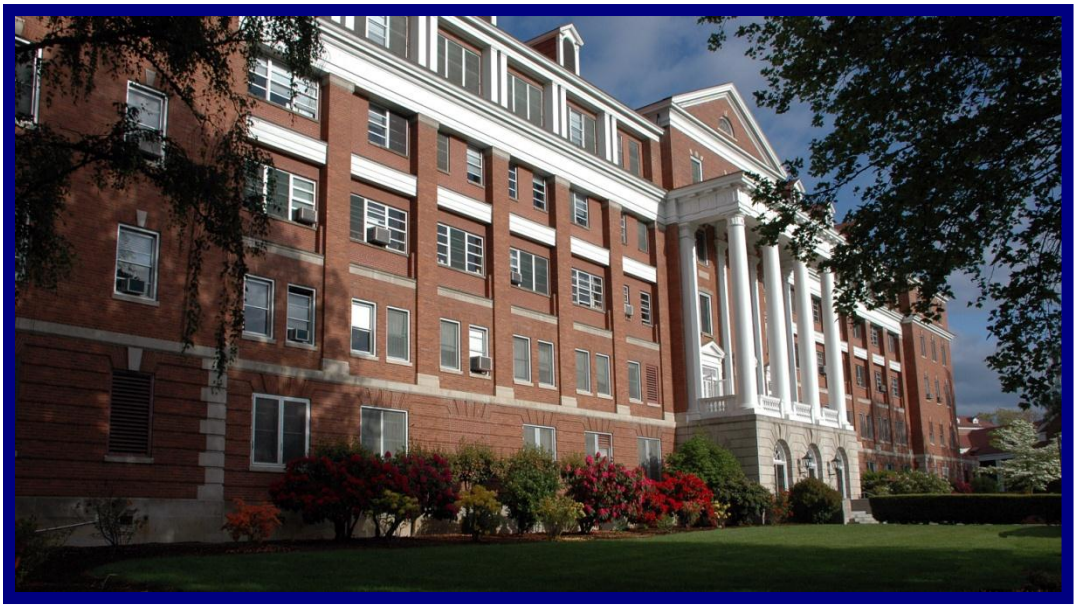
Medical Staff Bylaws
Rules and Regulations



VA ROSEBURG HEALTHCARE SYSTEM
June 2015
Roseburg, OR

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Table of Contents

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing within the VA Roseburg Healthcare System (VARHS) in Roseburg, Oregon (hereinafter sometimes referred to as VARHS), hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs, Veterans Health Administration (VHA), and bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the VHA, and they do not create any rights or liabilities not otherwise provided for in laws or VHA Regulations.

VARHS comprises the Medical Center in Roseburg, the Community Based Outpatient Clinics in Eugene, Brookings and North Bend, Oregon and Crescent City, California and the Behavioral Health Recovery and Reintegration Service center in Eugene, Oregon.

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

DEFINITIONS

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

1. Active Medical Staff. The Active Medical Staff shall consist of all full-time and part-time physicians, dentists, podiatrists, and optometrists who are professionally responsible for specific patient care and/or education activities of the healthcare system. Members of the Active Medical Staff shall be appointed to a specific organizational element, shall be eligible to vote, to serve on Medical Staff committees and shall attend Medical Staff meetings.

2. Affiliate Medical Staff. The Affiliate Medical Staff shall consist of those members of health professions who are qualified and privileged or have a scope of practice to assume specifically delineated direct patient care responsibilities. Individuals who hold membership on the Affiliated Medical Staff may be assigned a clinical advisor, appropriate to levels of expertise and experience, as specified in discipline specific VHA Directives, and shall carry out their activities subject to VARHS policies and procedures. Affiliate Medical Staff shall include certified registered nurse anesthetists, advanced practice registered nurses, and

psychologists; clinical pharmacy specialists with scope of practice and prescriptive privileges and physician assistants with scope of practice. They will be expected to serve on committees of the Medical Staff and shall have full voting rights. The titles, qualifications, clinical duties and responsibilities of specific categories are available in VHA Directives. Each Affiliate Medical Staff member works under a set of privileges specific to their discipline or scope of practice, which is approved by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.

3. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, mid-level and/or patient care services at the facility. Both VA employees and contractors who are providing patient care services must receive appointments to the Medical Staff.

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

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

6. Associate Medical Staff: The Associate Medical Staff shall consist of those duly appointed on-station fee basis, consultant, and attending physicians as well as physicians, dentists, podiatrists, psychologists, optometrists, physician assistants, advanced practice registered nurses, psychologists, clinical pharmacy specialists, etc., on contractual or With Out Compensation (WOC) appointments who are responsible for supplementing the practice of members of the Active Medical Staff in their roles in patient care, and education. Consultants, contract staff, and WOC staff will be appointed to a specific organizational element and shall be permitted to serve on committees. Associate Medical Staff are non-voting members and are not required to attend meetings of the Medical Staff unless specifically stipulated in the employment agreement.

7. Automatic Suspension of Privileges: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Examples exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.

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

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

10. Director: The Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the facility. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services/Nurse Executive (ADPCS), and the Executive Council of the Medical Staff.

11. Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging: This body is the committee on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matter to the Medical Center Director as defined in these Bylaws. This body also may act on matters involving Associate Medical Staff and Affiliate Medical Staff such as granting privileges, prescriptive authority, scope of practice, and appointment.

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

13. Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the VARHS to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians, dentists, podiatrists, advanced practice registered nurses (APRN) (who must possess a license from a state granting independent practice), optometrists and psychologists.

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

15. Mid-Level Practitioner: Mid-Level Practitioners are those health care professionals who are not physicians and dentists and who, most often, function within a Scope of Practice but may practice independently on defined clinical privileges as defined in these Bylaws. Mid-Level Practitioners may include: physician assistants (PA) and advanced practice nurses (APRN, CRNA, and CRNP). Mid-Level Practitioners may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations. If the state licensure of a Mid-Level Practitioners requires supervision; that Mid-Level Practitioner will be under the supervision of a credentialed and privileged Licensed Independent Practitioner (LIP) when required. Mid-Level Practitioners may have admitting privileges and may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations. Advanced Practice Registered Nurses and other health care professionals may be granted defined clinical privileges when allowed by law and the facility (this is a facility decision).

16. Associate Director for Patient Care Services/Nurse Executive: The Nurse Executive is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined

by Title 38. S/he is the Chairperson of the Executive Council of Nurses (ECN) and acts as assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant mid-level and certain associated health staff and in ensuring the ongoing education of the nursing staff.

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

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

19. Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant, with the exception that an MD/DO may complete a Peer Recommendation for a APRN or PA, reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner-specific data collected from various sources for the purpose of evaluating current competence. Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner-specific data collected from various sources for the purpose of evaluating current competence.

20. Primary Source Verification: Documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care Practitioner. This can be a letter, documented telephone contact, or secure electronic communication with the original source.

21. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.

22. Professional Standards Boards: The Professional Standards Board, if established, may act as a Credentials Committee on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matter to the Executive Committee of the Medical Staff as defined in these Bylaws. This board also may act on matters involving Associated Health and Mid-Level Practitioners such as granting prescriptive authority, scope of practice, and appointment. Some professional standards boards (e.g. Nursing, etc.) are responsible for advancement and other issues related to their respective professions.

23. Rules: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the Bylaws. They can be reviewed and revised by the Executive Council of the Medical Staff and without adoption by the Medical Staff as a whole. Such changes shall become effective when approved by the Director.

24. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a LIP to another LIP using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-on care is delivered at the site of the patient by a licensed independent health care provider. Providers in this category do not need to have current BLS at this facility and are credentialed at their home facility.

25. Telemedicine: The provision of care by a LIP that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.

26. VA Regulations: The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws. (Example: Code of Federal Regulation (CFR) 38 7402).

ARTICLE I: NAME

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

ARTICLE II: PURPOSE

The purposes of the Medical Staff shall be to:

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

2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.

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

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

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

6. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.

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

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

9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.

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

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

12. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident practitioners and other trainees.

13. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational publications.

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

ARTICLE III: MEDICAL STAFF MEMBERSHIP

Section 3.01 Eligibility for Membership on the Medical Staff

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent practitioners, and dentists who continuously meet the qualifications, standards, and requirements of VHA, the VARHS, and these Bylaws.

2. Categories of the Medical Staff:

   a. Active Medical Staff: The Active Medical Staff shall consist of all full-time and part-time physicians, dentists, podiatrists, and optometrists who are professionally responsible for specific patient care and/or education activities of the healthcare system. Members of the Active Medical Staff shall be appointed to a specific organizational element, shall be eligible to vote, to serve on Medical Staff committees and shall attend Medical Staff meetings.

   b. Affiliate Medical Staff: The Affiliate Medical Staff shall consist of those members of health professions who are qualified and privileged to assume specifically delineated direct patient care responsibilities. Individuals who hold membership on the Affiliated Medical Staff may be assigned a clinical advisor, appropriate to levels of expertise and experience, as specified in discipline specific VHA Directives, and shall carry out their activities subject to VARHS policies and procedures. Affiliate Medical Staff shall include certified registered nurse anesthetists, advanced practice registered nurses,

physician assistants, and psychologists (and clinical pharmacy specialists with scope of practice). They will be expected to serve on committees of the Medical Staff, and shall have full voting rights. The titles, qualifications, clinical duties and responsibilities of specific categories are available in VHA Directives. Each Affiliate Medical Staff member works under a set of privileges specific to their discipline or a Scope of Practice, which is approved by the Executive Session of the Executive Council of the Medical Staff.

c. Associate Medical Staff: The Associate Medical Staff shall consist of those duly appointed on-station fee basis, consultant, and attending physicians as well as physicians, dentists, podiatrists, psychologists, optometrists, physician assistants, advanced practice registered nurses, psychologists, clinical pharmacy specialists, etc. on contractual or With Out Compensation (WOC) appointments who are responsible for supplementing the practice of members of the Active Medical Staff in their roles in patient care, and education. Consultants, contract staff, and WOC staff will be appointed to a specific organizational element and shall be permitted to serve on committees. Associate Medical Staff are non-voting members and are not required to attend meetings of the Medical Staff unless specifically stipulated in the employment agreement.

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

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

1. Criteria for Clinical Privileges: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial:

   a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of

Columbia as required by VA employment and utilization policies and procedures.

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

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

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 VII or VIII or of these Bylaws for a position for which the VARHS has a patient care need, and adequate facilities, support services and staff.

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

h. English language proficiency, written and spoken.

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

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

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

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

1) Physicians
2) Dentists

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

1) Advanced Practice Registered Nurses
2) Optometrists
3) Podiatrists
4) Psychologists
5) Clinical Social Workers
6) Doctors of Pharmacy
7) Clinical Pharmacists
8) Audiologists
9) Speech Pathologists

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

1) Physician Assistants
2) Clinical Pharmacy Specialists

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

Section 3.03 Code of Conduct

1. Acceptable Behavior: The VA expects that members of the Medical Staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and the VA. Acceptable behavior includes the following: (1) being on duty as scheduled, (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a Medical Staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

2. Behavior or Behaviors that Undermine a Culture of Safety: VA recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. VA strongly urges its practitioners to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. 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.

   Behaviors or Behaviors that Undermine a Culture of Safety is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that Behavior or Behaviors that Undermine a Culture of

Safety is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, Behavior or Behaviors that Undermine a Culture of Safety may reach a threshold such that it constitutes grounds for further inquiry by the Executive Council of the Medical Staff into the potential underlying causes of such behavior. Behavior by a practitioner that is disruptive could be grounds for disciplinary action.

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

Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing Behavior or Behaviors that Undermine a Culture of Safety on the part of other providers. VA urges its providers to support their hospital, practice, or other healthcare organization in their efforts to identify and manage Behavior or Behaviors that Undermine a Culture of Safety, by taking a role in this process when appropriate. Please see MCM 653-007-010 (Workplace Violence Prevention) and MCM 653-005-022 (Employee Responsibility and Conduct) for additional information.

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

Section 3.04 Conflict Resolution & Management

For VA to be effective and efficient in achieving its goals the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Directive 5978.1, Alternative Dispute Resolution Program, addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. VHA expects VA medical center leadership to make use of these and other resources in communicating expectations to clinicians and other staff that conflictive, disruptive, inappropriate, intimidating, and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff who experience or

witness such behavior are encouraged to advise an appropriate supervisor, Patient Safety Officer, or other individual as described in the following Agency resources: *Alternative Dispute Resolution: VA Directive 5978.1, Alternative Dispute Resolution Program: Central Office (December 11, 2007) and station memorandums 653-000-012, Alternative Dispute Resolution and, Governance and Committee Structure 653-00B-004.*

ARTICLE IV: ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. Composition:

   a. Chief of Staff functions as the President of the Medical Staff.

   b. The Medical Staff, through its Committees, Services and Senior Professional Discipline Advisors, provides counsel, assistance, and recommendations to the Chief of Staff and Director regarding all facets of the patient care programs, including mission and services offered, continuous quality improvement, strategic plans and goals.

2. Qualifications: All Active Medical Staff members are eligible for membership on the Executive Council of the Medical Staff as elected members by their peers.

3. Selection: Selection, Appointment, Duties and Responsibilities of Associate Chief of Staff (ACOS).

   ACOSs are licensed independent providers appointed by the Director, VARHS based upon the recommendations of the Chief of Staff. The ACOS applicants' credentials will be reviewed through the privilege delineation process. , in which board certification by an appropriate specialty board or affirmation of comparable competence is established. Board Certification is preferred, however; VHA facilities may hired non-board certified physicians IAW VHA Directive 2001-001. In the event a non-board certified ACOS is selected, the facility Director and Chief of staff will ensure that any such non-board certified physician, or physician not eligible for board certification is otherwise well-qualified and fully capable of providing high quality care for Veteran patients.

   ACOSs are responsible and accountable for:

a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as Service Chief.
b. Clinically related activities of the Service.
c. Administratively related activities of the department, unless otherwise provided by the organization.
d. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges through FPPE/OPPE.
e. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service.
f. Recommending clinical privileges for each member of the Service.
g. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the Service and communicating the recommendations to the relevant organizational authority.
h. The integration of the Service into the primary functions of the organization.
i. The coordination and integration of interdepartmental and intradepartmental services.
j. The development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.
k. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.
l. The determination of the qualifications and competence of service personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services.
m. The continuous assessment and improvement of the quality of care, treatment, and services.
n. The maintenance of and contribution to quality control programs, as appropriate.
o. The orientation and continuing education of all persons in the service.
p. The assurance of space and other resources necessary for the service defined to be provided for the patients served.
q. Annual review of all clinical privilege forms to ensure that they correctly and adequately reflect the services being provided at the facility. This review is noted by date of review being included on the bottom of each privilege delineation form.

4. Selection, Appointment, Duties and Responsibilities of Senior Professional Discipline Advisors (SPDAs) Other Than ACOSs

Each professional discipline of the Medical Staff will have a Senior Professional Discipline Advisor. SPDAs are licensed independent providers appointed by the Director, VARHS, based upon the recommendations of the Chief of Staff or

Associate Director for Patient Care Services/Nurse Executive. A SPDA applicant's credentials will be reviewed through the privilege delineation process, in which board certification by an appropriate specialty board or affirmation of comparable competence is established.

SPDAs will work in conjunction with the respective ACOSs to:

a. Define and develop clinical privilege or scope of practice statements, including levels (or categories) of care that are specific for the specialties or sub-specialties associated with each discipline. This includes recommending the criteria for clinical privileges to the Medical Staff after development and approval of such criteria by members of the profession.

b. Develop criteria for recommending clinical privileges/scope of practice for those providers in each specialty.

SPDAs are responsible for:

a. Recommending appointment and clinical privileges for each member of the profession and others requesting privileges within the discipline.

b. Assuring timely and open communication between the professional disciplines, individual services, the ECMS, and top management.

c. Collaborating and acting as the subject matter expert on performance evaluations and on Focused Professional Evaluations and Ongoing Professional Evaluations.

5. Removal: Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Executive Council of the Medical Staff.

6. Duties:

a. Chief of Staff serves as Chairperson of the Executive Council of the Medical Staff and the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.

b. Duties of other Medical Staff Leaders:
   1) Each ACOS serves as a member of the Executive Council of the Medical Staff.
   2) Two elected Active Medical Staff members (elected for a two-year term) (two physicians)
   3) Three Affiliate Medical Staff members (elected for a two-year term)

Section 4.02 Leadership

The Medical Staff, through its committees and ACOS/Service Chiefs and SPDAs, provides counsel and assistance to the Chief of Staff and Director regarding all facets of patient care, treatment, and services including evaluating and improving the quality and safety of patient care services.

Section 4.03 Clinical Services

1. Characteristics:

   a. Clinical Services are organized to provide clinical care and treatment under leadership of the ACOS/Service Chief.

   b. Clinical Services hold service-level meetings at least four times per year.

2. Functions:

   a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care without privileges); patient satisfaction activities; patient safety and risk management activities; and utilization management.

   b. Assist in identification of important aspects of care for the Service, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care. Utilize VHA

performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities.

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

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

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

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

g. Annually review privilege templates for each Service and make recommendations to the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.

3. Selection and Appointment of ACOS's or Service Chiefs: The ACOS or Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff.

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

a. Completing Medical Staff Leadership and Provider Profiling online training within three months of appointment as ACOS/Service Chief.

b. Clinically related activities of the Service.

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

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

e. Recommending to the Medical Staff the criteria for clinical privileges or scope of practice that are relevant to the care provided in the Service.

f. Recommending clinical privileges or scope of practice for each member of the Service.

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

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

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

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

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

l. The determination of the qualifications and competence of service personnel who are not Licensed Independent Practitioners, who provide patient care, treatment, and services.

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

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

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

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

q. Annual review of all clinical privilege forms to ensure that they correctly and adequately reflect the services being provided at the VARHS. This review is noted by date of review being included on the bottom of each privilege delineation form. The same procedure applies for those practitioners with a scope of practice.

5. Each professional discipline of the Medical Staff will have a Senior Professional Discipline Advisor. SPDAs are licensed independent providers appointed by the Director, VARHS, based upon the recommendations of the Chief of Staff or Associate Director for Patient Care Services/Nurse Executive. The SPDA applicant's credentials will be reviewed through the privilege delineation process, in which board certification by an appropriate specialty board or affirmation of comparable competence is established.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.

2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.

3. The presence of twenty-five (25) percent of a committee's members will constitute a quorum.

4. The members of all standing committees, other than the ECMS, are appointed by the Chief of Staff and subject to approval by the ECMS, unless otherwise stated in these Bylaws.

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

6. Robert's Rules of Order Newly Revised will guide all committee meetings.

Section 5.02 Executive Council of the Medical Staff

1. Characteristics: The Executive Council of the Medical Staff (ECMS) serves as the Executive Committee of the Medical Staff. The members of the ECMS are:
   a. Chief of Staff (Chair), voting
   b. Associate Chief of Staff for Ambulatory Care, voting
   c. Associate Chief of Staff for Mental Health, voting
   d. Associate Chief of Staff for Medicine, voting
   e. Associate Chief of Staff for Surgery, voting
   f. Chief of Imaging, voting
   g. Associate Director Patient Care Services/Nurse Executive, voting
   h. One elected Active Medical Staff members (elected for a two-year term) (one LIP), voting
   i. One Affiliate Medical Staff members (elected for a two-year term), (e.g.: NP, PharmD, Psychologist, CRNA, PA), voting
   j. Ex-Officio Members (non-voting): Director, Quality Manager and Assistant to the Chief of Staff

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

l. Selection process for membership: All Active Medical Staff members are eligible for membership on the Executive Council of the Medical Staff as elected members by their peers. Membership is determined either by position within the healthcare system or by election.

m. Removal process for membership: Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Executive Council of the Medical Staff.

2. Functions of the ECMS:

a. The Executive Council of the Medical Staff (ECMS) is a body representative of the VARHS Medical Staff, which oversees the safety and quality of the care, treatment, and services provided by those individuals with clinical privileges.

b. ECMS functions include, but are not limited to:

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

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

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

4. Makes recommendations directly to the Director regarding the:

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

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

c) Delineation of privileges for each Practitioner credentialed.

5. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.
6. Oversees process in place for instances “for cause” concerning a medical staff member’s competency to perform requested privileges.
7. Oversees process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.
8. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.
9. Monitors medical staff ethics and self-governance actions.
10. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.
11. Receives and acts on reports and recommendations from medical staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body/Director.
12. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.
13. Acts upon recommendations from the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.
14. Acts as and carries out the function of the Physical Standards Board, which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational health Physician. The Physical Standards Board may have the same membership as the local physician Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging: or members may be designated for this purpose by the health care facility Director. Boards may be conducted at other VA healthcare facilities.
15. Provides oversight and guidance for fee basis/contractual services.
16. Annually reviews and makes recommendations for approval of the Service-specific privilege lists.

c. Meetings:

1. Regular Meetings: Regular meeting of the ECMS shall be held at least bi-monthly. The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chairmen of the various committees of the Medical Staff shall attend regular meetings of the ECMS when necessary to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the ECMS.
2. Emergency Meetings: Emergency meetings of the ECMS may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the ECMS the Director as the Governing Body or Acting Chief of Staff, acting for the Chief of Staff, may call an emergency meeting of the Committee.
3. Meeting Notice: All ECMS members shall be provided at least 7 calendar days advance written notice of the time, date, and place of each regular meeting and reasonable notice, oral or written, of each emergency meeting.
4. Agenda: The Chief of Staff, or in his absence, such other person as provided by these Bylaws, shall chair meetings of the ECMS. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.
5. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the ECMS shall be a majority of the voting members of the Council, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is 50% of voting members. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
6. Minutes: Written minutes shall be made and kept on all meetings of the ECMS, and open session minutes will be available for inspection by Practitioners who hold membership or privileges on the Medical Staff.
7. Communication of Action: The Chair at a meeting of the ECMS at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.

Section 5.03 Committees of the Medical Staff

1. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for Medical Staff

membership, (e) reviewing the activities of the Medical Staff and Mid-Level and Associated Health Professionals, (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners and (g) for such additional purposes as may be set forth in the charges to each committee.

The following list of physician-led committees and program reports are communicated to the ECMS per the reporting schedule delineated in the committee charters and approved ECMS reporting schedule. The committee's specific charge(s), membership, and meeting frequency are outlined in each committee's charter which has been approved by ECMS. Below are the committees and reports to ECMS:

a. Acute Care Advisory Board (ACAB)
b. Ambulatory Care Committee
c. Community Care Committee
d. Consult Committee
e. Credentials Committee
f. Disruptive Behavior Committee (DBC)
g. Home Oxygen Committee
h. ICD-10 Implementation Committee
i. Infection Control
j. Medical Records Committee
k. Mental Health Executive Council
l. Operative and Invasive Procedure Committee
m. Pain Advisory Committee
n. Patient Centered Care Committee
o. Peer Review Committee including Service-level Morbidity & Mortality Review
~~p.~~ Pharmacy, Therapeutics and Nutrition Committee: Medication Use, Drug Use Evaluations, Formulary Change
q. Prevention of Amputation in Veterans Everywhere (PAVE)
r. Prosthetics Committee
s. Social Work Practice Committee
t. Women Veterans Advisory Committee

u. Transfusion Utilization Committee

v. Fugitive Felon Committee

w. Reports:

1) Medical Contracts: This is a report to ECMS regarding the quality metrics of the medical contracts. It is provided bi-annually to ECMS.

2) Radiology: This is a report to ECMS on the quality metrics, workload, and resource needs of the service.

3) Laboratory: This is a report to ECMS on the performance and quality measures for the program.

4) Patient Safety: This is a report to ECMS on the performance and quality measures for the program.

2. Information Flow to ECMS: All Medical Staff Committees, including but not limited to those listed above, will submit Executive Summary reports and meeting minutes based on the reporting schedule defined in committee charter which has been approved by the Executive Council of the Medical Staff.

Section 5.04 Committee Records and Minutes

1. Committees prepare and maintain reports to include data, conclusions, recommendations, responsible person, actions taken, and evaluation of results of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff according to the approved ECMS reporting schedule.

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

3. Each committee shall review and forward to the Executive Council of the Medical Staff, a synopsis of any subcommittee and/or workgroup findings.

Section 5.05 Establishment of Committees

1. The Executive Council of the Medical Staff may, by resolution and upon approval of the Director, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions.

2. The Executive Council of the Medical Staff may, by resolution and upon approval of the Director, dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

ARTICLE VI. MEDICAL STAFF MEETINGS

1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least four times per year and at the call of the chairperson, or at the at least annually. A record of attendance shall be kept.

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

3. Quorum: For purposes of Medical Staff business, twenty-five% (25%) of the total membership of the Medical Staff membership entitled to vote constitutes a quorum.

4. Meeting Attendance: Members of the Medical Staff are required to attend twenty-five percent (25%) of regular Medical Staff meetings and fifty percent (50%) of Service-level meetings.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. Independent Entity: VARHS is an independent entity, granting privileges to the Medical Staff through the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging, and through the Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Mid-Level Practitioner, and Associate Health Professional reappointments may not exceed two (2) years, minus one day from the date of last appointment or reappointment date. Medical Staff and Mid-Level and Associated Health Professionals must practice under their privileges or scope of practice.

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

3. Deployment/Activation Status:

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

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

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

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

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

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

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

5. Initial Focused Professional Practice Evaluation (FPPE):

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

1) Criteria for conducting performance monitoring

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

3) Method for determining the duration of the performance monitoring

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

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

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

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

6. Ongoing Professional Practice Evaluation (OPPE):

The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the Medical Staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for Medical Staff leadership. Each ACOS/Service Chief should consider what hospital, regional, state, national, and

specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.

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

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

c. In those instances where a Practitioner does not meet established criteria, the ACOS/Service Chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude an ACOS/Service Chief recommending the renewal of privileges, but the ACOS/Service Chief must clearly document the basis for the recommendation of renewal of privileges.

d. The Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging must consider all information available, including the ACOS/Service Chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.

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

Section 7.02 Application Procedures

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

   a. Items specified in Article III, Section 3.02, Qualifications for Medical Staff Membership, including:

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

      2) Education.

      3) Relevant training and/or experience.

      4) Current professional competence and conduct.

      5) Physical and Mental health status.

      6) English language proficiency, written and spoken.

      7) Professional liability insurance (contractors only).

      8) Basic Life Support (BLS) for Healthcare Providers approved program using established criteria by the American Heart Association. Clinically active staff nominally includes all physicians, mid-level providers and nurses, MCM 653-118E-004.

      To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and will acknowledge that he/she has received a copy of “The Sedation and Analgesia by Non-Anesthesia Providers” policy and agrees to the guidelines outlined in the policy, MCM 653-100-002 - Moderate Sedation by Non-Anesthesia Providers and MCM 653-100-001 - Out of OR Airway Management. Initial privileges require FPPE per policy.

Discipline-specific members of the Medical Staff are required to have current Advanced Cardiac Life Support (ACLS) per MCM 653-118E-004. Anesthesia providers are the only providers privileged to use deep sedation.

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

c. References: The names and addresses of a minimum of three (3) individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer or for individuals completing a residency; one reference must come from the residency training program director. The Director may require additional information.

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

   1) Name of health care institution or practice.

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

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

e. DEA/CDS Registration:

   1) Status, either current or inactive.

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

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

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

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

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

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

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

a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article III, Section 3.02 above.

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 7.03 Process and Terms of Appointment

1. ACOS or Chief of Service Recommendation: The Chief of the Service or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical Staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met.

2. CMO Review: In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be submitted to the VISN 20 Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the ECMS 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 20 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 20 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 20 CMO review will be documented on the (ACOS) Service Chief's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

3. Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

4. Director Action: Recommended staff appointments to the Medical Staff should be acted upon by the Director within thirty (30) work days of receipt of a fully complete application, including all required verifications, references and recommendations from the appropriate Service Chief and the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.

5. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or return of the application because of inadequate information.

Section 7.04 Credentials Evaluation and Maintenance

1. Evaluation of Competence: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the Practitioner applying for clinical privileges has demonstrated current competence in professional performance,

judgment and clinical and/or technical skill to practice within clinical privileges requested.

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

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

4. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a “for-cause” event requiring a focused review, MCM 653-011-017.

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

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

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

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

   1) Criteria for conducting the FPPE.

   2) Method for monitoring for specifics of requested privilege.

   3) Statement of the “triggers” for which a “for-cause” FPPE is required.

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

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

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

   1) Extension of FPPE review period

   2) Modification of FPPE criteria

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

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

Section 7.05 Local/VISN 20-Level Compensation Panels

Local/VISN 20-level Compensation Panels recommend the appropriate pay table, tier level and market pay amount for individual Medical Staff members, as outlined in VA Handbook 5007, Part IX. Appointment actions recommended by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging require a separate review for a pay recommendation by the appropriate Compensation Panel.

ARTICLE VIII CLINICAL PRIVILEGES

Section 8.01 General Provisions

1. Clinical privileges are granted for a period of no more than two (2) years.

2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's ACOS or Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.
    a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.
    b. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.
    c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging. 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).
3. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the ACOS/Service Chief.

4. Associated Health and Mid-Level Practitioners who are permitted by law and the VARHS to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.

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

6. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient

service area. In those instances where clinical privileges cross to a different designated service, all ACOS/Service Chiefs must recommend the practice.

7. Exercise of clinical privileges within any Service is subject to the rules of that Service and to the authority of that ACOS/Service Chief.

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

9. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN 20 policies. Providers in this category do not need to have current Basic Life Support (BLS) at this facility.

10. Teleconsultation: All Practitioners providing Teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN 20 policies. Providers in this category do not need to have current BLS at this facility.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.

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

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

   a. Complete appointment information as outlined in Article VII.

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

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

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

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

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

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

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

i. Evidence of successful completion of an approved BLS for Healthcare Providers program meeting the established criteria of the American Heart Association. Providers of Telemedicine and Teleconsultation do not need to have current BLS at this facility.

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

5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that s/he has received a copy of Moderate Sedation by Non-Anesthesia Providers MCM 653-100-002 and MCM 653-100-001, Out of OR Airway Management and agrees to the guidelines outlined in these policies

Section 8.03 Process and Requirement for

Requesting Renewal of Clinical Privileges

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:
   a. An application for clinical privileges as outlined in Section 8.02 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate ACOS/Service Chief prior to formal submission of privilege requests.
   b. Supporting documentation of professional training and/or experience not previously submitted.
   c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Medical Staff. Reasonable evidence of health status may be required by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.
   d. Documentation of continuing medical education related to area and scope of clinical privileges, (consistent with minimum state licensure requirements) not previously submitted.
   e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.
   f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within fifteen (15) days of the adverse action.
   g. Names and addresses of two peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

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

2. Verification: Before granting subsequent clinical privileges, the Medical Staff Office will ensure that the following information is on file and verified with primary sources, as applicable:
   a. Current and previously held licenses in all states.
   b. Current and previously held DEA/State CDS registration.
   c. NPDB Continuous Query Registration.
   d. FSMB query
   e. Physical and mental health status information from applicant.
   f. Physical and mental health status confirmation.
   g. Professional competence information from peers and ACOS/Service Chief, based on results of OPPE and FPPE.
   h. Continuous education to meet any local requirements for privileges requested.
   i. Board certifications, if applicable.
   j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the ACOS/Service Chief. This request will initiate the recredentialing process as noted in the VHA Handbook 1100.19.

2. Primary source verification is conducted if applicable, e.g. provider attests to additional training.

3. Current NPDB Continuous Query Registration prior to rendering a decision.

4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging followed by the Director's/ Governing Body's approval.

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

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

2. The ACOS/Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.

   a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:

      1) Medical/Clinical knowledge.

      2) Interpersonal and Communication skills (documentation).

      3) Professionalism.

      4) Patient Care.

      5) Practice-based Learning & Improvement.

      6) System-based Practice.

   b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE).

3. The Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging, recommends granting clinical privileges for the practitioner to the Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws.

4. Clinical privileges are acted upon by the Director within thirty (30) work days of receipt of the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging recommendation to appoint. The Director's action must be verified with an original signature.

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

   Note: *Any changes made to a practitioner's request for clinical privileges during the review and approval process must be well documented to include all communication with the practitioner and the reason for the changes. Removal or non-renewal of requested privileges may require appropriate due process proceedings as this may require reporting to the National Practitioner Data Bank.*

6. The process for Scope of Practice is identical to privileges. For those mid-level providers with privileges and prescriptive authority, appropriate license for prescriptive authority is available for review in Credentialing and Privileging folder at the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.

Section 8.06 Exceptions

1. Temporary Privileges for Urgent Patient Care Needs: Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of an initial appointment for a limited period of time (not to exceed sixty (60) calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff.
   a. Temporary privileges are based on verification of the following:
      1) One, active, current, unrestricted license with no previous or pending actions.
      2) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.
      3) Current comparable clinical privileges at another institution.
      4) Response from NPDB Continuous Query registration with no match.
      5) Response from FSMB with no reports.

6) No current or previously successful challenges to licensure.

7) No history of involuntary termination of Medical Staff membership at another organization.

8) No history of voluntary limitation, reduction, denial, or loss of clinical privileges at another organization.

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

b. A completed application must be submitted within three (3) calendar days of temporary privileges being granted and credentialing completed.

2. Expedited Process: Renewal privileges are those privileges that can be approved by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging via a virtual meeting. Virtual meetings are generally reserved for situations in which there are no major issues to be discussed. In the event of a virtual meeting, any voting member of the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging may request a face-to-face meeting if they feel that it is indicated. A quorum must be met. A quorum is defined as at least fifty percent (50%) of the voting membership.

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

b. The Facility:

1) Verifies education and training;

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

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

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

5) Receives 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.

6) Verifies current comparable privileges held in another institution; and

7) Receives a response from NPDB Continuous Query registration with no match.

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

9) Verifies that there is no history of involuntary termination of Medical Staff membership at another organization.

10) Verifies that there is no history of voluntary or involuntary limitation, reduction, denial, or loss of clinical privileges.

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

c. The Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging recommends appointment to the Medical Staff.

d. The recommendation by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging must be acted upon by the Director.

e. Full credentialing must be completed within sixty (60) calendar days of the date of the Director's/Governing Body's signature and presented to the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging for approval.

3. Emergency Care: Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate.

4. Disaster Privileges: As described in the VARHS Emergency Management Plan :

a. In the event of the implementation of the organization-wide disaster management plan, Disaster Privileges may be approved by the Chief of Staff/Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging if it is determined that it is not possible to handle the influx of patients with the existing Practitioners.

b. Disaster Privileges. In circumstances of disaster(s) in which the emergency management plan has been activated, the Director or the Chief of Staff or their designee may grant disaster privileges to LIPs who may be needed to meet emergent clinical requirements in the most efficient and expedited manner. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains the following:

1) Valid government-issued photo identification (for example, a driver's license or passport),
2) Current picture identification card from a health care organization that clearly identifies professional designation,
3) Current license to practice - Primary Source Verification of licensure; and one of the following:
    a) Identification indicating that the individual is a member of a:
        - Disaster Medical Assistance Team (DMAT),
        - Medical Reserve Corps (MRC),
        - Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP),
        - Other recognized state or federal response organization or group.

    b) Identification indicating that the individual has been granted authority by a health care entity to provide patient care, treatment, or services in a health care facility; or confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

The disaster privileges will be granted for a period of ten (10) days or for the length of the disaster or emergency, whichever is shorter, or until communication is established and the practitioner can be moved to the "Temporary Appointment" category for urgent patient care needs. Primary source verification of licensure will be obtained within seventy-two (72) hours after the disaster is under control, or as soon as possible in extraordinary circumstances.

c. Disaster Privileges will be processed by the Medical Staff Office, with privileges being signed by the Chief of Staff and Medical Center Director.
d. Volunteer LIPs will be issued with an ID name tag, with "Volunteer LIP" on the front, and with their name, specialty and date of issue on the back. Name tags will be kept in the Medical Staff Office and personalized at time of disaster.
e. LIPs with disaster privileges are monitored by direct observation during the disaster and by medical record review once the disaster is over.
f. If by observation and consensus, Medical Staff feel that a LIP with disaster privileges should not continue to provide care during the disaster, they will be asked to leave by the Chief of Staff or designee.

g. Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within seventy-two (72) hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within seventy-two (72) hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following: reason(s) it could not be performed within seventy-two (72) hours of the practitioner's arrival; evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; evidence of the hospital's attempt to perform primary source verification as soon as possible.

h. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within seventy-two (72) hours of the practitioner's arrival, it is performed as soon as the immediate emergency situation is under control.

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

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

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

6. Deployment and Activation Privilege Status: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment. **NOTE**: No step in this process should be a barrier in preventing the Practitioner from returning to VARHS in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.

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

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

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

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

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

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

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

h. If the file cannot be brought to a verified status and the Practitioner's privileges restored by the Director, the Practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed sixty (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:

1) Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.
2) Registration with the NPDB Continuous Query with no match.
3) A response from the FSMB with no match.
4) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.
5) Documentation of the Temporary Appointment on the Appointment Screen not to exceed sixty (60) calendar days.

Section 8.07 Medical Assessment

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

ARTICLE IX INVESTIGATION AND ACTION

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

improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. NOTE: If the person under review is an employee then the processes must also follow VA Directive 5021 - Management of Employees.

2. Fact Finding Process: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article IX, a fact finding process will be implemented. This fact-finding process should be completed within thirty (30) days or there needs to be documentation as to why that was not possible. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities and/or professional conduct the Practitioner are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff or to represent Professional Misconduct, Behavior or Behaviors that Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging or professional standards board.

3. Review by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging: The Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging investigates the charges and makes a report of the investigation. The Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging has fourteen (14) days from the conclusion and review of the report to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging to discuss, explain or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging is an administrative matter and not an adversarial Hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations.

4. Executive Council of the Medical Staff Action: Within fourteen (14) days after receipt of a report the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging acts upon the request. If the action being considered by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging, prior to the committee's action on such request. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. A record of such proceeding is made by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging.
    a. The Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging may reject or modify the recommendations; impose terms of probation or a requirement for consultation; recommend reduction, suspension or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommend that the Practitioner's staff membership be suspended or revoked.
    b. Any recommendation by the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging, for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.
    c. Reduction of privileges may include, but not be limited to, functioning under supervision[1], restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.
    d. Revocation of privileges refers to the permanent loss of clinical privileges.
5. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, all or a portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Director.

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

a. The Chief of Staff convenes the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging to investigate the matter, meet with the Practitioner if requested and make a report within fourteen (14) days after the effective date of the Summary Suspension.

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

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

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

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

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

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

4) Failure to maintain the mandatory requirements for membership to the Medical Staff.

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

b. The Chief of Staff convenes the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging or Professional Standards Board (PSB) to investigate the matter and make a report within fourteen (14) days after the effective date of the Automatic Suspension.

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

d. If there are more than three (3) automatic suspensions of privileges in one calendar year, or more than twenty (20) days of automatic suspension in one calendar year, a thorough assessment of the need for the Practitioner's services must be performed and documented and appropriate action taken.

7. Actions Not Constituting Corrective Action: The Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:
   a. The appointment of an ad hoc investigation committee;
   b. The conduct of an investigation into any matter;
   c. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview or conference before the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging, any ad hoc investigating committee, the Chief of Staff, or any other committee or sub-committee with appropriate jurisdiction in connection with any investigation prior to a proposed adverse recommendation or action;
   d. The failure to obtain or maintain any other mandatory requirement for Medical Staff membership;
   e. The imposition of proctoring or observation of a Medical Staff member which does not restrict clinical privileges or the delivery of professional services to patients;
   f. Corrective counseling;
   g. A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education; or
   h. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.

ARTICLE X FAIR HEARING AND APPELLATE REVIEW

1. Reduction of Privileges:
   a. Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:
      1) A description of the reason(s) for the change.
      2) A statement of the Practitioner‘s right to be represented by counsel or a representative of the individual’s choice, throughout the proceedings.

b. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff's written notice of intent. The Practitioner must submit a response within ten (10) workdays of the Chief of Staff's written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed 10 additional workdays except in extraordinary circumstances.

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

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

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

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

      1) Be present throughout the evidentiary proceedings

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

      3) Cross-examine witnesses.

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

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

4. The panel must complete the review and submit the report within fifteen (15) workdays from the date of the close of the Hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.
   a. The panel's report, including findings and recommendations, must be forwarded to the Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.
   b. The Director must issue a written decision within ten (10) workdays of the date of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the Director constitutes a final action and the reduction is reportable to the NPDB.
   c. If the Practitioner wishes to appeal the Director’s decision, the Practitioner may appeal to the appropriate VISN 20 Director within five (5) workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director’s decision is overturned on appeal, the report to the NPDB must be withdrawn.
   d. The VISN 20 Director must provide a written decision, based on the record, within twenty (20) workdays after receipt of the Practitioner's appeal.

      NOTE: The decision of the VISN 20 Director is not subject to further appeal.

5. The Hearing panel chair shall do the following:
   a. Act to ensure that all participants in the Hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the Hearing process.
   b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a Hearing will last no longer than a total of fifteen (15) hours.
   c. Maintain decorum throughout the Hearing.
   d. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
   e. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the Hearing is considered by the Hearing panel when formulating its recommendations.

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

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

Practitioner Rights:

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

a. The panel will complete its review and submit its report within fifteen (15) workdays of the date of the Hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.

b. The Director will issue a written decision within ten (10) workdays of the day of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.

c. The Practitioner may submit a written appeal to the VISN 20 Director within five workdays of receipt of the Director's decision.

d. The VISN 20 Director will provide a written decision based on the record within twenty (20) workdays after receipt of the Practitioner's appeal. The decision of the VISN 20 Director is not subject to further appeal.

e. A Practitioner who does not request a review panel Hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN 20 Director within five workdays after receipt of the Director's decision.

f. The review panel Hearing defined in Article X Section 2 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.

g. If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her Medical Staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, if greater than thirty (30) days, such action is reported without

further review or due process to the NPDB and the appropriate state licensing boards.

6. Revocation of Privileges:

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

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

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

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

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

   a. Tort ("malpractice") claims are filed against the United States government, not individual Practitioners. There is no direct financial liability for named or involved Practitioners. Government attorneys (Regional Counsel, General Counsel, U.S. Attorney) investigate the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.

[2] Reference VHA Handbook 1100.17.

b. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioners should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.

c. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist regional and general counsel in defending the case and in decisions concerning denial or settlement.

d. Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to the Practitioner involved in the plaintiff's case when a tort claim settlement is submitted for review.

e. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physicians and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g., fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges (38 CFR part 46.4). The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than thirty (30) days, and the final action will be reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension, if greater than thirty (30) days, will be reported.

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

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

ARTICLE XI RULES AND REGULATIONS

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

ARTICLE XII AMENDMENTS

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from Executive Council of the Medical Staff. Changes to the Bylaws are amended, adopted and voted on by the Medical Staff as a whole and then approved by the Director. The Bylaws are amended and adopted by fifty-one percent (51%) endorsement of the voting Active Medical Staff.

2. The Executive Council may provisionally adopt and the Director may provisionally approve urgent amendments to the Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the medical staff. After adoption, these urgent amendments to the Rules and Regulations will be immediately communicated back to the Organized Medical Staff for retrospective review and comment on the provisional amendment. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.04 should be followed.

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

4. All changes to the Bylaws require action by both the Medical Staff and Director. Neither may unilaterally amend the Bylaws.

5. Changes are effective when approved by the Director.

ARTICLE XIII ADOPTION

These Bylaws shall be adopted as described in Article XII. They shall replace any previous Bylaws and shall become effective when approved by the Director.

If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy or an amendment thereto, they must first communicate the proposal to the Executive Committee. If the Executive Committee proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the medical staff. When the Executive Committee adopts a policy or amendment thereto, it must communicate this to the medical staff. This applies only when the organized medical staff, with the approval of the Director, has delegated authority over such rules, regulations, or policies to the Executive Committee. The communication may be accomplished by regular or special meeting of the Medical Staff, or by electronic notice.

RECOMMENDED

Bilal Chaudhry, MD — Date

Chief of Staff

APPROVED

Douglas V. Paxton, Sr., MSW — Date

Interim Director

MEDICAL STAFF RULES AND REGULATIONS

1. GENERAL

a. The Rules relate to role and/or responsibility of members of the Medical Staff in the care of any and all patients.
b. Rules of Services will not conflict with each other, rules and policies of the Medical Staff, or with requirements of the Governing Body.
c. The Medical Staff as a whole shall hold meetings at least annually.
d. The Executive Council of the Medical Staff serves as the executive committee of the Medical Staff and between the regular bimonthly meetings, acts in their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.
e. Each of the Clinical Services shall conduct meetings at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by Medical Staff and responsible party of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.
f. Information used in quality improvement as referenced in Article IX, cannot be used when making adverse privileging decisions.

2. PATIENT RIGHTS

a. Patient's Rights and Responsibilities: The VARHS supports the rights of each patient and publishes policy and procedures to address rights including each of the following:
    1) Reasonable response to requests and need for service within capacity, mission, laws and regulations.
    2) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
    3) Collaboration with the Practitioner in matters regarding personal health care, MCM 653-011-022.
    4) Pain management including assessment, treatment and education.
    5) Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.
    6) Formulation of advance directives and appointment of surrogate to make health care decisions (38 CFR17.32 and MCM 653-011-006).

7) Access to information necessary to make care decisions that reflect patient's wishes, including potential outcomes, risks and benefits and consequences of refusal of treatment.
8) Access to information about patient rights, handling of patient complaints.
9) Participation of patient or patient's representative in consideration of ethical decisions regarding care.
10) Access to information regarding any human experimentation or research/education projects affecting patient care.
11) Personal privacy and confidentiality of information.
12) Action by a legally authorized person to exercise a patient's rights if a patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or unable to communicate his/her wishes.
13) Authority of a surrogate decision maker to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available) MCM 653-011-022.
14) Foregoing or withdrawing life-sustaining treatment including resuscitation.
15) Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.

b. Living Will, Advance Directives, and Informed Consent (38 CFR 17.32, MCM 653-011-022, and MCM 653-011-006).

1) Competent patients have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.
2) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the physician in consultation with, as appropriate, other members of the treatment team (38 USC section 7331).
3) With respect to the documentation of decision making concerning life-sustaining treatment, the following information, at a minimum, will be documented in the progress notes by the attending physician: The

patient's diagnosis and prognosis; an assessment of the patient's decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.

4) Competent patients will be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning life-sustaining treatment will be honored, and will be documented in the medical record.
5) Advance Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any competent patient may execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a declarant at any time.
6) Substituted Judgments: The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:
    a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.
    b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.

c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision-making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the attending physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body, or Chief of Staff.

3. RESPONSIBILITY FOR CARE

A. Conduct of Care

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

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

b) A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or

a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA regulations and hospital policy. The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.

Medical Assessment of the patient may include the Medical history, including:

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

c) The Staff Practitioner responsible for the patient must sign the admission note if it is prepared by a resident, intern, or Mid-Level Practitioner, where applicable, or make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" or make whatever comments he/she thinks the case warrants or prepare a complete admission within forty eight (48) hours of admission to the CLC. In the event a r Mid-Level practitioner prepares an admission workup, all will be retained, but the official workup will contain the responsible Medical Staff Practitioner's approval signature.

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

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

f) Progress notes will be written by the Practitioner at least once daily on all acutely ill patients. Progress notes are written for all patients seen for ambulatory care by the Medical Staff.

g) Evidence of required supervision of all care by the Staff Practitioner shall be documented in the medical record, the frequency of notes dependent upon the severity of the illness of the patient. It is a cardinal principle that responsibility for the care of each patient lies with the Staff Practitioner to whom the patient is assigned.

h) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written in the patient's medical record. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility of the Staff Practitioner to ensure that the order and its meaning are discussed with appropriate members of the VARHS staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.

i) Patients will not be transferred out when the Medical Center has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer only after authorization is given by the appropriate provider as defined in facility policy MCM 1516.

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

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

B. Consultations:

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

a) The diagnosis is obscure, and/or

b) There is doubt as to the best therapeutic measures to be utilized, and/or

c) The patient is not a good risk for an operation or treatment.

2) Consultant: A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff and the Executive Session of the Executive Council of the Medical Staff for Credentialing and Privileging on the basis of an individual's training, experience, and competence.
3) Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.
4) Responsibility for Requesting Consultations: The patient's practitioner, through the appropriate ACOS/Chief of Service, shall make certain that members of the staff do not fail in the matter of providing consultation as needed.
5) Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.

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

1) Discharge planning provides for continuity of care to meet identified needs.
2) Discharge planning is documented in the medical record.
3) Criteria for discharge are determined by the Multidisciplinary Treatment Team.
4) Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.

D. Discharge

1) Patients shall be discharged from VARHS only upon the written order of the Practitioner and the discharge summary will be completed (signed) and available for review in CPRS within 2 business days of discharge from the inpatient setting and 3 business days for CLC residents. At time of completing the final summary, the responsible member of the Medical Staff shall review the medical record to ensure that documents therein pertain to the patient and contain accurate data. The record shall be completed within thirty (30) days of the discharge of the patient. The Practitioner shall complete his/her portion of the record within thirty (30) days, including authentication.

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

E. Autopsy

1) Autopsy services are provided by Laboratory and Pathology Service. The availability of these services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within VARHS.
2) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-170. Whenever possible, the physician responsible for the care of the patient at the time of death, will be designated to request permission from the next of kin to perform an autopsy.
3) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.170 and VHA Handbook 1106.01 Autopsy Services.
4) Autopsy Rates: Autopsies are encouraged as per VHA policy.
5) Autopsy Criteria. VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described MCM 653-113-003. Those cases meeting criteria as Medical Examiner's cases per policy will be referred to the appropriate County Medical Examiner's Office in accordance with state statutes.
6) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes.

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

4. PHYSICIANS' ORDERS

a. General Requirements

1) Orders are entered into the electronic medical record (EMR).
2) Verbal orders are strongly discouraged except in emergency situations.

3) Telephone orders will be accepted when the practitioner is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS. They will be accepted by Registered Nurses, Pharmacists, Physician Assistants, Advanced practice registered nurses, Certified Registered Nurse Anesthetists, etc., as designated by facility policy and when it clearly is in the best interest of patient care and efficiency. Appropriate staff receiving the order telephonically will first write down the verbal order and read back the order to the practitioner to ensure correctness. Verbal/telephone orders will be entered by the nurse or pharmacist, authenticated within the time frame specified by law and regulation and signed electronically by the practitioner as per policy designated within MCM 653-005-004.

b. Medication Orders

1) All drugs used at VARHS must be on the National Formulary and additions as approved by the VISN 20 Pharmacy, Therapeutics and Nutrition (PT&N) Committee and the Facility PT&N committee. Exceptions to the foregoing requirements may be made in use of "provisional drugs" or "non-formulary drugs" which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN 20 level. Exceptions are based on an individual patient case by case basis.
2) All drugs used at VARHS will be stored and dispensed by the Pharmacy.
3) Duration of Orders:

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

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

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

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

4) Ambulatory Care Medication Orders:

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

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

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

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

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

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

d. Informed Consent:

1) Informed consent will be consistent with legal requirements and ethical standards, as described in the facility policy concerning Informed Consent, MCM 653-011-022.
2) Evidence of receipt of Informed consent, documented in the medical record, is necessary in the medical record before procedures or treatment for which it is required, MCM 653-011-022.

e. Submission of Surgical Specimens: All specimens removed during a surgical procedure, whether in the Operating Room, Urgent Care, or Clinic area, will be sent to the pathologist with the following exceptions:

1) Bone segments removed as part of corrective or reconstructive orthopedic procedures.
2) Cataracts removed by phacoemulsification.
3) Dental appliances.
4) Foreign bodies (such as bullets) or other medico legal evidence that are given directly to law enforcement personnel.
5) Intrauterine contraceptive devices without attached soft tissue.
6) Medical devices such as catheters, gastrostomy tubes, myringotomy tubes, stents, and sutures that have not contributed to patient illness, injury, or death.
7) Middle ear ossicles.

8) Orthopedic hardware and other radiopaque mechanical devices.
9) Rib segments or other tissue removed only for the purpose of gaining surgical access from patient without history of malignancy.
10) Skin or other normal tissue removed during reconstructive procedure (e.g., blepharoplasty) that is not contiguous with a lesion and that is taken from a patient who does not have a history of malignancy.
11) Teeth without attached soft tissue.
12) Toenails and fingernails which are grossly unremarkable.

Documentation must be provided for the removal and disposition of any specimen or device not submitted to pathology. This specifically includes any failed medical devices that may have contributed to patient injury, any failed device for which litigation is pending or likely, and for devices subject to tracking under the Safe Medical Devices Act of 1990.

f. Special Treatment Procedures:
   1) DNR (Do Not Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment, MCM 653-011-005.
      a. A description of the role of the practitioner, family members and when applicable, other staff involved decision making.
      b. Mechanisms for reaching decisions about withholding of resuscitative services, including mechanisms to resolve conflicts in decision making.
      c. Documentation in the medical record.
      d. Requirements are described in Medical Center Memoranda, Medical Staff Bylaws, and these Rules.
   2) Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and may be utilized only within the guidelines of an established protocol in the MCM 653-100-002 and according to approved privileges and may only be given by those Practitioners with approved and current privileges to do so.

5. ROLE OF ATTENDING STAFF

a. Supervision of Non-Physicians
   1) Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment.
   2) Mid-Level and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

b. Documentation of Supervision of Resident Physicians

1) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.
2) Entries in the medical record made by non-physicians (e.g., PAs, ARNPs, etc.) that require countersigning by supervisory or attending medical staff members are covered by appropriate Facility policy and include:
    1) Medical history and physical examination.
    2) Discharge Summary.
    3) Operative Reports.
    4) Medical orders that require co-signature.
        a. DNR.
        b. Withdrawing or withholding life sustaining procedures.
        c. Certification of brain death.
        d. Research protocols.
        e. Investigational drug usage, ONLY permitted by named principal investigators or co-investigators previously designated in the study.

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

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

7. MEDICAL RECORDS

a. Basic Administrative Requirements:

1) Entries must be electronically entered where possible, which automatically dates, times, and authenticates with methods to identify author, which may include written signatures.
2) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Mid-Level Practitioners (where applicable).
3) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in MCM 2812, and is available in CPRS and VISTA. Those abbreviations are not acceptable for use either handwritten or in CPRS.
4) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within twenty-four (24) hours.
5) Release of Information (ROI) is required per MCM 653-136-006 and standard operating procedures for VARHS. All medical records are confidential and the property of VARHS and shall not be removed from the premises without permission (ROI from the Patient/consultation with the Privacy Officer as appropriate). Medical records may be removed from VARHS's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.
6) All medical records are confidential and are the property of the facility, and shall not be removed from the premises without permission (ROI from the Patient/consultation with the Privacy Office as appropriate). Medical records may be removed from the facility's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.
7) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

b. All Medical Records must contain:

1) Patient identification (name, address, DOB, next of kin).
2) Medical history including history and details of present illness/injury.
3) Observations, including results of therapy.
4) Diagnostic and therapeutic orders.
5) Reports of procedures, tests and their results.
6) Progress notes.
7) Consultation reports.

8) Diagnostic impressions.
9) Conclusions at termination of evaluation/treatment.
10) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in MCM 653-011-022, "Informed Consent."

c. Inpatient Medical Records: In addition to the items listed in section b above, all inpatient records should contain, at a minimum:

1) A history that includes chief complaint, history of present illnesses, childhood illnesses, adult illnesses, operations, injuries, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, chief complaint, and review of systems;
2) A complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self-care, mentation, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient-assessed personal history. Key examination medical impressions will be documented in the note. The note must be authenticated by provider at the earliest possible time, but always within twenty-four (24) hours of being written in CPRS.

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

b) Inpatient H&P must be completed within twenty-four (24) hours, and forty-eight (48) hours for long term care.

3) A discharge plan (from any inpatient admission), including condition on discharge.
4) Have a discharge summary (signed) (from inpatient) available for review in CPRS within 2 business days of discharge from the inpatient setting and 3 business days for CLC residents.
5) Completed within thirty (30) days of discharge.

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

1) A progress note for each visit.
2) Relevant history of illness or injury and physical findings including vital signs.
3) Patient disposition and instruction for follow-up care.
4) Immunization status, as appropriate.

5) Allergies.
6) Referrals and communications to other providers.
7) List of significant past and current diagnoses, conditions, procedures, drug allergies,
8) Medication reconciliation, clinical problem(s), and any applicable procedure and operations on the Problem List.

e. Surgeries and Other Procedures:

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

2) Preoperative Documentation:

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

b) Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical or Subjective/Objective/Assessment/Plan (SOAP) note addressing pertinent positive/negative information, indications for the procedure, known risks related to the procedure, and a physical exam pertinent to the procedure. A formal consultation to the Service for performing the procedure that includes all required content will serve as an H&P if done within thirty (30) days, but must be updated the day of the procedure.

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

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

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

1) The immediate post-operative note must include:

a) Pre-operative diagnosis,

b) Post-operative diagnosis,

c) Technical procedures performed,

d) Surgeons,

e) Findings,

f) Specimens removed, blood loss and

g) Complications

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

a) Anesthesia,

b) Drains,

c) Tourniquet Time(if applicable), or

d) Plan.

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

h. Post Anesthesia Care Unit (PACU) Documentation:

1) PACU documentation must include the patient evaluation on admission to, and discharge from, the post-anesthesia care unit, a time-based record of vital signs and level of consciousness (either paper or electronic), all drugs administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post-procedural complications, and post-anesthesia visits.

2) The health record must document the name of the LIP responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.
3) For inpatients, there needs to be at least one documented post-anesthesia visit after leaving the post-anesthesia care unit. The note needs to describe the presence or absence of anesthesia-related complications.
4) For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery, to assess any complications, including anesthetic complications, as appropriate.

8. INFECTION CONTROL

a. Hand-washing, isolation, and other infection control precautions will be adhered to as outlined in the Blood-borne Pathogen Exposure Plan and the Infection Control Plan.

b. Reportable public health cases are reported promptly to infection control personnel. The infection control personnel will make the formal report as required by Oregon Administrative Rules 433.004 and Oregon Revised Statutes 333-018-000. If infection control personnel cannot be reached within the reporting timeframe, the provider will make the initial report to the state health department, as outlined in the Infection Control Plan.

c. Standard Precautions are described in Infection Control Policy.

9. CONTINUING MEDICAL EDUCATION

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

10. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

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

a. Where there is evidence that a practitioner's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief

of Staff's office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their ACOS/Service Chief or Chief of Staff.

b. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by The State Licensing Board's Diversion Programs for Health Professionals for the state which the Practitioner is licensed, MCM 653-011-016.

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

d. VA and VARHS policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for LIPs, dentists and other healthcare professionals, MCM 653-011-016.

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

f. The hospital will sponsor periodic educational program regarding illness and impairment issues. Licensed independent Practitioners will be issued written information regarding illness issues at the time of initial appointment and re-appointment to the Medical Staff.

11. PEER REVIEW

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

b. All Medical Staff members will complete ongoing required training associated with VHA policy and MCM 653-00B-013.

12. SMOKING POLICY

a. All staff members are responsible for ensuring that the smoke-free environment is maintained at the VA Roseburg Healthcare System. This is accomplished through education and awareness of smoking cessation assistance available to all staff and patients and the familiarity with the locations of areas where smoking is permitted in accordance with 653-138-023 and VHA Directive 2008-052.

13. DISCLOSURE POLICY

a. It is the policy of the VARHS for all adverse events, patients or their personal representatives must be informed of the occurrence of any adverse event that has resulted in, or can be expected to result in, harm to the patient, in accordance with MCM 653-00B-017 and VHA Directive 2008-002.

14. QUALITY MANAGEMENT

a. The Medical Staff is responsible for Quality Management.
   1) Monitoring and ensuring the quality and safety of clinical medical practice within the facility.
   2) Contributing to effective quality management through clinical leadership.
   3) Participating in facility quality management activities.
   4) Ensuring a data driven process for granting and renewing clinical privileges based on appropriate initial and ongoing evaluations of training, competency, and performance is present at the facility.

15. TIME AND ATTENDANCE

a. Tours of Duty for Part-Time and Intermittent Employees.

   Part-time employees perform duty on less than a full-time basis and have a regularly scheduled tour of duty that is less than 80 hours in a biweekly pay period. Such employees may perform occasional unscheduled duty in addition to the regular tour of duty. Employees serve on an intermittent duty basis when employed on less than a full-time basis and have no prescheduled regular tour of duty, in accordance with MCM 653-011-019.

16. PATIENT SAFETY INITIATIVES

a. The Patient Safety Improvement Program is designed to create safe and efficient environments for the delivery of high quality care and to identify systems that could qualify as evidence of innovative practices and those that would benefit from redesign. Strategies are aimed at preventing injuries to patients, visitors, and personnel and managing those injuries that do occur to minimize the negative consequences to the injured individuals and VARHS. At least annually, one high-risk process will be identified for proactive risk assessment that is based in part on information published by the Joint Commission that identifies the most frequently occurring types of sentinel event and safety risk factors.

b. The Chief of Staff and the ECMS is responsible for directing, coordinating, and monitoring of clinical services to ensure appropriate and timely delivery of patient care services in as safe an environment as possible.

c. The LIP is responsible for clearly explaining the results of any treatments or procedure to the patient and, when appropriate, the family. This includes whenever those results differ significantly from the anticipated results, in accordance with MCM 653-00B-014.

17. SUICIDE RISK ASSESSMENT

a. An evaluation of current suicide risk will be conducted for any Veteran with a primary diagnosis or primary complaint of an emotional or behavioral disorder. While an evaluation of suicide risk is not required with Veterans having a secondary diagnosis or secondary complaint of emotional or behavioral disorders, providers should consider the need for such evaluation in these cases.

b. An evaluation of current suicide risk will also be conducted for any Veteran with a positive clinical reminder for depression or Post-traumatic stress disorder (PTSD). In addition, suicide risk will be evaluated in mental health settings at the first outpatient appointment, upon admission to and discharge from an inpatient unit or Mental Health Residential Rehabilitation Treatment Program (MHRRTP), at least once a year and whenever suicide has been identified as a clinically relevant issue.

   Suicide risk will be evaluated in non-mental health settings at all emergency room visits, and with all new pain consults. All Veterans with a Category II High Risk for Suicide flag will have suicide addressed at all primary care and mental health appointments.

All of the above evaluations are done in the form of Preliminary Suicide Risk Assessment. The Comprehensive Suicide Risk Assessment is required for all positive Preliminary Assessments and with admission to the Mental Health Unit and MHRRTP, in accordance with MCM 653-116-006.

Adopted by the Medical Staff, VA Roseburg Healthcare System, this XX of March 2015.

RECOMMENDED

Recommend/Not Recommend

Bilal Chaudhry, MD, FACHE
Chief of Staff

Date

Approve/Not Approve

Douglas V. Paxton, Sr., MSW
Director

Date 6/4/15

2015 BYLAWS REFERENCES

Records Control Schedule, 10-1

http://www1.va.gov/vhapublications/rcs10/rcs10-1.pdf

38 USC 7402 Qualifications of Appointees

http://vlex.com/vid/sec-qualifications-appointees-19233546

5 CFR 2635 Office of Government Ethics, Standards of Ethical Conduct for Employees of the Executive Branch

http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title05/5cfr2635_main_02.tpl

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38 USC 7401

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5 USC 3301 Civil Service

http://vlex.com/vid/sec-civil-service-generally-19265864

38 USC 7405 Temporary full-time appointments, part-time appointments, and WOC appointments

http://vlex.com/vid/temporary-full-appointments-without-19233532

38 USC 5705 Confidentiality of Medical Quality Assurance Records

http://www.law.cornell.edu/uscode/38/usc_sec_38_00005705----000-.html

Rehabilitation Act of 1974

http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=ED453622&ERICExtSearch_SearchType_0=no&accno=ED453622

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Public Law 99-660 Health Care Quality Improvement Act of 1986

http://www.socialsecurity.gov/OP_Home/comp2/F099-660.html

VHA Handbook 1100.17 National Practitioner Data Bank (NPDB) Reports

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38 USC 46.4 Clinical Privileges Action Reporting

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CFR 17.33 Patient's Rights

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38 CFR §17.32 Informed Consent and Advanced Healthcare Planning

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VHA Handbook 1004.01 Informed Consent for Clinical Treatments and Procedures

http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=2055

VHA Handbook 1004.02 Advanced Care Planning and Management of Advance Directives

http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=2967

38 USC 7331 Informed Consent

http://www.gpo.gov/fdsys/granule/USCODE-2011-title38/USCODE-2011-title38-partV-chap73-subchapIII-sec7331

VHA Handbook 1400.1 Resident Supervision

http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=2847

VHA Handbook 1004.3 Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA)

http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=1150

VHA Handbook 1106.01 Pathology and Laboratory Medicine Service Procedures

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1779

38 CFR § 17.170 Autopsies (17-155 in Template)

http://law.justia.com/us/cfr/title38/38-1.0.1.1.19.0.195.110.html

VHA Directive 2007-015 Inter-Facility Transfer Policy

http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1561

VHA Handbook 1108.02Inspection of Controlled Substances

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HA Handbook 1605.1 Privacy and Release of Information

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38 USC 7332 Confidentiality of Certain Medical Records

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VA Directive 5019 Occupational Health

http://vaww.publichealth.va.gov/docs/employeehealth/5019.pdf

VHA Directive 2008-052 Smoke-Free Policy for VA Health Care Facilities

http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1752

VHA Directive 2008-002 Disclosure of Adverse Events to Patients

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VHA Directive 2009-043 (061 in template-reissued as 043) Quality Management System

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http://www4.va.gov/oig/54/reports/VAOIG-06-03706-126.pdf

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