

BYLAWS AND RULES OF THE MEDICAL STAFF

FARGO VA HEALTH CARE SYSTEM

FARGO, ND

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PREAMBLE

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

DEFINITIONS

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

1. **Appointment**: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, Mid-level and/or patient care services at the facility. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.
2. **Associate Director for Operations and Resources**: The Associate Director fulfills the responsibilities of the Fargo VA HCS Director as defined in these bylaws when serving in the capacity of Acting Director, when so appointed.
3. **Associate Director for Patient Care (Nurse Executive)**: The Associate Director for Patient Care is responsible for the full-time, direct supervision of nursing services and chairs the Nursing Executive Committee. S/he acts as full assistant to the Fargo VA HCS Director in the efficient management of clinical and patient care services and the active maintenance of a credentialing and scope of practice system for relevant mid-level and certain associated health staff. The Associate Director fulfills the responsibilities of the Fargo VA HCS Director as defined in these bylaws when serving in the capacity of Acting Fargo VA HCS Director, when so appointed.
4. **Associated Health Professional**: As used in this document, the term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine. These professionals include, but are not limited to: Pharmacists (PharmDs), psychologists, podiatrists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.
5. **Automatic Suspension of Privileges**: Suspensions are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Examples are: exceeding the allowed medical record delinquency rate

(only if 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 Medical Executive Committee (MEC).

6. Chief of Staff: The Chief of Staff is the President of the medical staff and Chairperson of the Credentials Committee and the MEC. S/he acts as full assistant to the Fargo VA HCS 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 Providers, Mid-level Providers, and Associated-Health Providers. The Chief of Staff ensures the ongoing medical education of medical staff, is a member of the VA Affiliation Partnership Council, and is the professional liaison between the Medical Center and the Council. The Chief of Staff fulfills the responsibilities of the Fargo VA HCS Director as defined in these bylaws when serving in the capacity of Acting Fargo VA HCS Director, when so appointed.
7. 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 and must be operated in accordance with VA policies and procedures.
8. Credentials Committee: The Credentials Committee oversees credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matters to the Medical Executive Committee (MEC) as defined in these Bylaws. This committee also acts on matters involving Associated Health and Mid-Level Providers such as granting prescriptive authority, scope of practice, and appointment.
9. Focused Professional Practice Evaluation (FPPE): Focused professional practice evaluation is a process whereby the organization evaluates the privilege-specific competence of the Provider who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged Provider's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the provider's professional performance. Focused Professional Practice Evaluation occurs at the time of initial appointment and prior to granting new or additional privileges.
10. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration. For purposes of local facility management and planning, it refers to the Fargo VA HCS Director. The Fargo VA HCS Director is responsible for the oversight and delivery of health care by all employees and specifically including the medical staff credentialed and privileged by the relevant administrative offices and facility approved processes.
11. Licensed Independent Provider: The term Licensed Independent Provider (LIP) refers to any individual permitted by law and by the Fargo VA HCS 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, psychologists, optometrists, and podiatrists.

12. Management (Unprotected) Peer Review: Any review that is conducted for purposes other than confidential quality improvement and/or resource utilization related to individual provider decisions. It needs to be clearly understood and communicated (verbally and in writing) from the onset of a management review that findings are and can be disclosed. NOTE: Although the protected findings may serve as the trigger for a non-protected review, these same findings are protected (confidential) and cannot be disclosed. Unprotected management review activities include, but are not limited to:
 - A. A review of activities of clinical staff to assess and attest to competency of professional staff for the purpose of considering an adverse clinical privileging action.
 - B. A review of activities performed for the purpose of a board of administrative investigation.
 - C. A review of activities performed for the purpose of assisting the United States in consideration of tort claims or defenses of litigation under the Federal Tort Claims act, particularly if the review is done at the request of the Regional Counsel of the Assistant United States Attorney.
 - D. A review of activities related to the Credentials Committee conducted for the purpose of potentially reducing or removing privileges.
 - E. Peer recommendation forms used for credentialing and privileging.
 - F. Reviews conducted while considering clinical privileges.
 - G. Occupational Safety and Health Administration investigations.
13. Fargo VA HCS Director: The Fargo VA HCS Director is appointed by the Governing Body to act as its agent in the overall management of the Fargo VA HCS. The Fargo VA HCS Director is assisted by the Chief of Staff (COS), the Associate Director for Operations and Resources (AD), the Associate Director for Patient Care/Nurse Executive, and the Medical Executive Committee (MEC).
14. Medical Staff: All fully Licensed Independent Providers and other Providers who are permitted by law, and the Fargo VA HCS, to provide patient care services independently in this medical center and its community-based outpatient clinics.
15. Mid-Level Provider: Mid-Level Providers 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 Providers include: physician assistants (PA), and advanced practice nurses (APRN, CRNA, and CRNP). Mid-Level Providers may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations, under the supervision of a credentialed and privileged Licensed Independent Provider when required. Mid-Level Providers do not have admitting privileges and may initiate prescriptions for non-formulary drugs

or prescribe controlled substances in accordance with state of licensure statutes and regulations.

16. Organized Medical Staff: The body of Licensed Independent Providers who are collectively responsible for adopting and amending medical staff bylaws (i.e., those with voting privileges) and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges.
17. Ongoing Professional Practice Evaluation (OPPE): The ongoing practice evaluation of privileged Providers and providers to confirm the quality of care delivered and ensure patient safety. Such identification may require intervention by the organized medical staff. Information and data considered must be Provider or provider specific, and could become part of the Provider's provider profile analyzed in the facility's on-going monitoring (see VHA Handbook 1100.19).
18. Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Provider's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Provider-specific data collected from various sources for the purpose of evaluating current competence.
19. 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 Provider. This can be a letter, documented telephone contact, or secure electronic communication with the original source.
20. Proctoring: Proctoring is the activity by which a Provider is assigned to observe the practice of another Provider performing specified activities and to provide required reports on those observations. If the observing Provider is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Provider to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.
21. Quality (Protected) Peer Review: Protected peer review documents for quality improvement include all reviews of patient care by an individual provider that are performed for the purpose of improving the quality of health care and/or improving the utilization of health care resources. Each peer review must be designated in writing as being conducted and/or prepared for quality improvement and/or resource utilization purposes prior to the initiation of the peer review. NOTE: As long as confidentiality is maintained and appropriately documented, data from protected peer reviews can be aggregated and communicated to the organized professional staff for the purpose of promoting organizational performance (including appropriate resource utilization) and optimal patient outcomes.
22. Rules: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the Bylaws. They can be reviewed and revised by the MEC and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Fargo VA HCS Director.

23. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another LIP using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider
24. Telemedicine: The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.
25. VA Affiliation Partnership Council: Council established by a formal Memorandum of Affiliation between the Fargo VA HCS and the University of North Dakota School of Medicine and Health Sciences, approved by the Under Secretary for Health, to consider and advise on development and management and evaluation of all educational and research programs conducted at the Medical Center. The Council is composed of deans and senior faculty members of the University of North Dakota School of Medicine and Health Sciences and representative(s) of the medical/dental staffs of the Fargo VA HCS; and such other faculty of the affiliated schools and staff of the Fargo VA HCS (including the Associate Director for Patient Care/Nurse Executive) as appropriate.
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).
27. VetPro: An internet enabled data bank for the credentialing of VHA personnel that facilitates completion of a uniform, accurate, complete credentials file.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Fargo VA Health Care System, Fargo, North Dakota. The Medical Staff oversees the quality of patient care, treatment and services provided to patients by Providers with privileges. It reports to and is accountable to the Fargo VA HCS Director.

ARTICLE II. PURPOSE

The primary function of the organized Medical Staff is to oversee the quality of patient care, treatment and services provided by Providers privileged through the medical staff process and to:

1. Assure that all patients treated at the Fargo VA Health Care System, including its Community Based Outpatient Clinics (CBOC's), will receive uniform quality of patient care, treatment, and services including efficient; timely; and appropriate care that is subject to performance improvement practices.
2. Establish and assure adherence to ethical standards of professional practice and conduct.
3. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.

4. Provide an appropriate and effective educational setting that will ensure the continuous advancement of medical education and research by participation and consultation under the coordination of the Chief of Staff and the VA Affiliation Partnership Council.
5. Maintain a high level of professional performance of Providers authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
6. Assist the Fargo VA HCS Director in developing and maintaining rules for Medical Staff governance and oversight.
7. Provide a medical perspective, as appropriate, to issues being considered by the Fargo VA HCS Director.
8. 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.
9. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.
10. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
11. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.
12. 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.
13. Coordinate and supervise the scope of practice of all Mid-Level and appropriate Associated Health Provider 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 Provider 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 fully licensed physicians, dentists, optometrists, psychologists, and podiatrists who continuously meet the qualifications, standards and requirements of the Veterans Health Administration (VHA), the Fargo VA Health Care System, and these Bylaws.
2. Membership may be considered for other licensed Providers who are permitted by law to provide patient care services independently and who meet the qualifications, standards and requirements of the VHA, the Fargo VA Health Care System, and these Bylaws.

3. All medical staff members, and all others with delineated clinical privileges, are subject to the Medical Staff Bylaws and medical center policies, and are subject to review as part of the organization's performance improvement activities.

4. Categories of the Medical Staff:

- A. The Active Medical Staff:

- 1) The Active Medical Staff shall consist of licensed physicians, dentists, optometrists, psychologists, and podiatrists, who are full-time or part-time VA employees, who are professionally responsible for specific patient care and/or education and/or research activities of the hospital and who assume all the functions and responsibilities of membership on the Active Medical Staff.
 - 2) Members of the Active Medical Staff, other than those in specifically administrative positions, shall be appointed to a specific Service Line (SL) or Service, shall be eligible to vote at Medical Staff Committee meetings on the Bylaws and their amendments, to hold office, to serve on medical staff committees, and shall be required to attend assigned meetings unless excused.

- B. The Contracted/Consultant Medical Staff:

- 1) The Contracted/Consultant Medical Staff shall consist of providers, employed through a contracting agency, or as a consultant, of recognized professional ability and competence who may be responsible for the provision of direct patient care diagnosis, treatment or care of patients.
 - 2) Members who hold membership on only the contracted/consultant staff shall be appointed to a specific Service Line/Service. They may be on ad hoc committees of the Medical Staff but shall not be permitted to vote or to hold office and are not required to attend Medical Staff meetings.

- C. Resident/House Staff:

Resident/House Staff are those individuals who are engaged in an ACGME accredited formal program of post-graduate training and education approved by VA's Office of Academic Affairs, and who participate in patient care under the direction of licensed staff physicians who have clinical privileges in the areas they are supervising. Residents may attend meetings, but are not permitted to vote or hold office.

- D. Associated Health Professional Staff:

The Associated Health Professional Staff shall be divided into Clinical Doctoral Scientists and mid-level providers (see Definitions, above). Associated Health Professional Staff may attend meetings of the Medical Staff and are permitted to vote or hold office.

5. 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.

6. Appointment or reappointment, to the Medical Staff, or repriviliging of Associated Health Professionals will be for a period of not more than two (2) years.
7. Criteria for removal from Medical Staff membership are:
 - A. Failure to follow the requirements of the Bylaws of the Medical Staff
 - B. Failure to adhere to the Rules and Regulations of the Medical Staff
 - C. Reduction or revocation of privileges
 - D. Engaging in clinical or interpersonal behavior which is of sufficient import so as to raise the question of improper or substandard clinical conduct or competence.
8. Termination of medical staff appointments will be accomplished in conjunction with the procedures for terminating appointments of providers set forth in VA Handbook 5021 parts II, III, and VI.

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 the requirements of 3.01 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.
 - 1) A temporary license will be considered acceptable only if it is time limited in nature and is issued because the provider has not completed a required period of residence in the State or has not yet obtained United States citizenship.
 - 2) The licensure requirement may be waived if the appointment is to an academic or research position or to a position where there is no direct responsibility for patient care. Responsibility for direct patient care is defined as any examination or instrumentation to establish a diagnosis or a report thereon by the physician or dentist, which influences or determines therapy, as well as prescribing and writing orders for or otherwise treating a patient.
 - B. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine, Osteopathy, or Dentistry from an accredited 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 ACGME or AOA internship, residencies, fellowships, board certification, and other specialty training.

- D. Current clinical 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 and clinical privileges granted.
 - F. Complete information consistent with requirements for application and clinical privileges as defined in Articles VI or VII or of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, to support services and staff.
 - G. Satisfactory findings relative to previous professional competence and professional conduct.
 - H. English language proficiency.
 - I. For those individuals providing service under contract. Current professional liability insurance as required by Federal and VA acquisition regulations.
 - 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).
 - K. Ability to be physically present at the medical center within 30 minutes response time (for all categories of medical staff with on-call responsibilities). This clause is not applicable to those applicants who are accepted for telehealth only positions.
2. Clinical Privileges and Scope of Practice: While only Licensed Independent Providers may function with defined clinical privileges, not all Licensed Independent Providers are permitted by this Facility and these Bylaws to practice independently. All Providers listed below and appointed to the Medical Staff, are subject to the bylaws whether they are granted defined clinical privileges or not.
- A. The following Providers will be credentialed and privileged to practice independently:
 - 1) Physicians
 - 2) Dentists
 - B. The following Providers will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:
 - 1) Advanced Practice Nurses
 - 2) Clinical Social Workers
 - 3) Doctors of Pharmacy
 - 4) Clinical Pharmacists
 - 5) Psychologists
 - 6) Audiologists

- 7) Speech Pathologists
- 8) Podiatrists
- C. Optometrists: The following Providers will be credentialed and will practice under a Scope of Practice with appropriate supervision:
 - 1) Physician Assistants.
 - 2) Clinical Pharmacists.
 - 3) Unlicensed Psychologists.
- D. The following Providers will be credentialed and will practice under a Scope of Practice with appropriate supervision when not granted clinical privileges as in B above.
 - 1) Advanced Practice Nurses/Advanced Practice Registered Nurses including CRNAs.
- 3. Change in Status: Members of the Medical Staff and all Providers 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. The Fargo VA HCS Director, through the Chief of Staff, will be advised of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges which are held, and any changes in the status of professional credentials. Such changes may be, but are not limited to: loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society. Notification will be made as soon as able, but no longer than 15 days after notification of the provider.

Section 3.03 Code of Conduct

- 1. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following at a minimum (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, (7) abide by the Hatch Act.

2. Behavior or Behaviors that Undermine a Culture of Safety: VA recognizes that the manner in which its Providers interact with others can significantly impact patient care. VA strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal 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. Conduct that could intimidate others may affect quality of care and patient safety, and will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, involve rude and/or disrespectful language, be threatening, or involve physical contact.

Behavior or Behaviors That Undermine a Culture of Safety is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that behavior or behaviors that undermine a culture of safety is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, behavior or behaviors that undermine a culture of safety may constitute grounds for further inquiry by the Medical Executive Committee into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action, up to and including dismissal.

VA distinguishes behavior or behaviors that undermine the culture of safety from constructive criticism that is offered in a professional manner with the aim of improving patient care. VA also reminds its providers of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a provider's health and performance. Providers suffering such symptoms are encouraged to seek help. The Employee Assistance Program is available for confidential help for all employees.

Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing behavior or behaviors that undermine the 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 the culture of safety, by taking a role in this process when appropriate.

3. Professional Misconduct: Behavior that compromises ethical standards will not be tolerated. Staff should avoid even the appearance of misconduct.

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 of conflict in order to avoid a lack of progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program*, addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. 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.

ARTICLE IV: ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. Composition:
 - A. Chief of Staff
 - B. Associate Chiefs of Staff (ACOS) for Service Lines or Services
 - C. Medical Directors for the Service Lines or Services.
2. Qualifications:
 - A. In addition to the requirements for medical staff membership, the Chief of Staff is board certified.
 - B. In addition to the requirements for medical staff membership, criteria for appointment as ACOS or Medical Director include Board Certification/or equivalent experience and comparable training as vetted through the credentialing process.
3. Selection:
 - A. The Chief of Staff is appointed by the Under Secretary for Health of the Department of Veterans Affairs. A Search Committee is convened to conduct the search and interviews. Separate from these Bylaws, and in compliance with VAVHA Policy, the organization determines how the Chief of Staff search is to be conducted, how each candidate's qualifications are reviewed, and how recommendations are made to the Fargo VA HCS Director as to the quality and selection of the applicant.
 - B. ACOSs and Medical Directors are appointed by the Fargo VA HCS Director based upon the recommendation of the Chief of Staff. A Search Committee is convened to conduct the search and interviews. When the Service Line Director is not a board certified, credentialed and privileged clinician, a Medical Director of the Service Line who is credentialed and privileged, and preferably board

certified clinician, will collaborate with the Service Line Director in areas where clinical judgment and competence are required. Separate from these Bylaws, and in compliance with VAVHA Policy, the organization determines how the Service Line/Service ACOS or Medical Director search is to be conducted, how each candidate's qualifications are reviewed, and how recommendations are made to the Chief of Staff as to the quality and selection of the applicants.

4. Removal from Medical Staff Leadership:

- A. The decision to remove will be made by the Fargo VAHCS Director and is not subject to appeal.

Criteria for removal are:

- 1) Failure to follow the requirements of the Bylaws of the Medical Staff
- 2) Failure to adhere to the Rules and Regulations of the Medical Staff
- 3) Reduction or revocation of privileges due to criteria in Section 3
- 4) Failure to perform the administrative functions of their position in a professional and competent fashion.

5. Duties:

- A. The Chief of Staff is the President of the Medical Staff and Chairperson of the Credentials Committee and the MEC. He/she acts as full assistant to the Fargo VA HCS Director in the efficient management of clinical and medical services to eligible patients. The COS is also responsible for the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Providers, Mid-level Providers, and Associated Health Providers. The Chief of Staff ensures the ongoing medical education of medical staff. S/he is a member of the VA Affiliation Partnership Council and is the professional liaison between the medical center and the Council. The Chief of Staff fulfills the responsibilities of the Fargo VA HCS Director as defined in these bylaws when serving in the capacity of Acting Fargo VA HCS Director, when so appointed.

- B. Duties and Responsibilities of Service Line/Service ACOSs: The Service Line/Service ACOS is administratively responsible for the operation of the Service/Service Line and its clinical and research efforts, as appropriate. In addition to duties listed below, the Service Line/Service ACOS is responsible for assuring the Service/Service Line performs according to applicable VHA performance standards. These are the performance requirements applicable to the Service/Service Line 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 Service Line/Service ACOS. Service Line/Service ACOSs are responsible and accountable for:

- 1) Completing Credentialing and Privileging on-line training, consisting of Medical Staff Leadership and Medical Staff Performance Profiles, Parts I and II, within three months of appointment as Service Line/Service ACOS.

- 2) Clinically related activities of the Service/Service Line.
- 3) Administratively related activities of the Service/Service Line, unless otherwise provided by the organization.
- 4) Continued surveillance of the professional performance of all individuals in the Service/Service Line who have delineated clinical privileges through FPPE/OPPE.
- 5) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service/Service Line.
- 6) Recommending clinical privileges for each member of the Service/Service Line.
- 7) Assessing recommendations for off-site sources of patient care, treatment, and services not provided by the Service/Service Line and communicating the recommendations to facility leadership.
- 8) Integration of the Service/Service Line into the primary functions of the organization.
- 9) Coordination and integration of interdepartmental and intradepartmental services.
- 10) Development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.
- 11) Assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.
- 12) Determination of the qualifications and competence of service personnel who are not licensed independent Providers and who provide patient care, treatment, and services.
- 13) Continuous assessment and improvement of the quality of care, treatment, and services.
- 14) Maintenance of and contribution to quality control programs.
- 15) Orientation and continuing education of all persons in the Service/Service Line.
- 16) Assessment and planning of space and other resources necessary for the Service/Service Line defined to be provided for the patients served.
- 17) Annual review of all clinical privilege forms to ensure they correctly and adequately reflect the services being provided at the facility.
- 18) Supervising research, education, and training programs within the SL in cooperation with the chairperson of the appropriate academic department(s) and the consulting and attending staffs.
- 19) Preparing and/or assisting in the preparation of reports and documents pertaining to the SL as required by the Medical Executive Committee, the Chief of Staff, or the Fargo VA HCS Director.

- 20) Counseling, appropriately, any provider who is found to be deficient in continuing medical education, in any clinical area, or where another deficit has been identified.

Section 4.02 Organized Medical Staff Leadership

1. The Organized Medical Staff, through its committees and Service Line/Service ACOSs, provides counsel and assistance to the Chief of Staff and Fargo VA HCS 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

2. Characteristics:

- A. Clinical Services are organized to provide clinical care and treatment under leadership of an ACOS for the Service or Service Line for Primary Care and Specialty Medicine Service Line, Imaging Service, Pathology and Laboratory Medicine Service, Mental Health Service Line, and Surgery and Specialty Care Service Line.
- B. Clinical Services will hold service-level meetings at least monthly. Minutes will be distributed to appropriate staff members and the Chief of Staff within fourteen (14) days following the conclusion of the meeting.

3. Functions: Clinical Services will:

- A. Provide for quality and safety of the care, treatment, and services provided by the Service/Service Line. This requires ongoing monitoring and evaluation of:
 - 1) quality and safety (including access, efficiency, and effectiveness);
 - 2) appropriateness of care, and treatment (including that provided under temporary privileges or emergency care in the absence of formal privileges);
 - 3) patient satisfaction activities;
 - 4) patient safety and risk management activities;
 - 5) utilization management.
- B. Assist in identification of important aspects of care for the Service/Service Line, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care.
- C. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of SL/Service activities.
- D. 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 facility policy no later than fourteen (14) business days following the conclusion of the meeting.

- E. Develop criteria for recommending clinical privileges for members of the SL/Service and ensure that ongoing professional practice evaluation is continuously performed and results are utilized at the time of re-privileging.
- F. Define and/or develop clinical privilege statements including levels (or categories) of care that include all requirements of VHA Handbook 1100.19.
- G. Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within the SL/Service.
- H. Annually review privilege templates for each Service and make recommendations to the MEC.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

- 1. Committees are either standing or ad hoc.
- 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 a simple majority of voting members will constitute a quorum.
- 4. The members of all standing committees, other than the Medical Executive Committee (MEC), are appointed by the Chief of Staff subject to MEC approval, unless otherwise stated in these Bylaws.
- 5. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff.
- 6. Robert's Rules of Order will govern all committee meetings.

Section 5.02 Executive Committee of the Medical Staff (MEC)

- 1. Characteristics: The MEC serves as the Executive Committee of the Medical Staff. The members of the MEC are selected by virtue of their position. The members of the MEC are:
 - A. Voting Members:
 - 1) Chief of Staff, Chairperson
 - 2) Service Line/Service ACOSs
 - a) Primary Care and Specialty Medicine Service Line
 - b) Surgery and Specialty Care Service Line
 - c) Mental Health Service Line
 - d) Pathology and Laboratory Medicine Service
 - e) Imaging Service
 - f) Extended Care and Rehabilitation Service Line
 - 3) Assistant ACOSs for Clinical Services/Service Lines

- a) Assistant ACOS for Specialty Medicine Service
 - b) Primary Care
- 4) Member-at-Large appointed by the Chief of Staff from the members of the active medical staff, position to be rotated every two years.
- 5) Associate Director for Patient Care/Nurse Executive
- 6) Director, Research Service
- 7) Chief, Pharmacy Service
- 8) Director, Emergency Department
- B. Non-voting members:
 - 1) Director of Performance Improvement
 - 2) Clinical Resources Management Nurse
 - 3) Compliance Officer
 - 4) Administrative Officer to the Chief of Staff
 - 5) Fargo VA HCS Director, or designee, ex-officio
- C. Other facility staff as may be called upon to serve as resources or attend committee meetings at the request of the chairperson, with or without vote. For example, a Physician Assistant may be called to be present when an action affecting another Physician Assistant is being considered. Any member of the Medical Staff (with or without vote) is eligible for consideration.
- D. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
- E. Criteria for removal from MEC are:
 - 1) Failure to follow the requirements of the Bylaws of the Medical Staff
 - 2) Failure to adhere to the Rules and Regulations of the Medical Staff
 - 3) Reduction or revocation of privileges
 - 4) Failure to perform the administrative functions of their position in a professional and competent fashion.
 - 5) Change in credentials or position to one not specified in paragraph A of this Section.
 - 6) Personal or professional behavior inconsistent with a leadership role.
- 2. Functions of the MEC:
 - A. Acts on behalf of the Medical Staff between Medical Staff meetings. MEC is delegated primary authority over activities related to the functions of self-governance of the Medical Staff and over activities related to focused reviews of provider performance, patient safety, quality management and performance improvement of the professional services provided by individuals with clinical

privileges. Authority is delegated by adoption of these bylaws and may be revoked by amendment to the bylaws.

- B. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness. Additionally, addresses the scope and quality of services provided within the facility.
- C. Acts to ensure effective communications between the Medical Staff and the Fargo VA HCS Director.
- D. Makes recommendations directly to the Fargo VA HCS Director regarding the:
 - 1) Organization, membership (to include termination), structure, and function of the Medical Staff.
 - 2) Process used to review credentials and delineate privileges for the Medical Staff.
 - 3) Delineation of privileges for each provider credentialed.
- E. Coordinates ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.
- F. Oversees “for-cause” process regarding a Medical Staff member’s competency to perform requested privileges.
- G. Oversees process by which membership on the Medical Staff may be terminated consistent with applicable laws and VA regulations.
- H. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.
- I. Monitors medical staff ethics and self-governance actions.
- J. Advises Chief of Staff and Fargo VA HCS Director and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.
- K. Receives and acts on reports and recommendations from Medical Staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups, making needed recommendations to the Fargo VA HCS Director.
- L. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.
- M. Acts upon recommendations from the Credentials Committee.
- N. Acts as and carries out the function of the Physical Standards Board, which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician. The Physical Standards Board may have the same membership as the Credentials Committee or members may

be designated for this purpose by the health care facility Director. Boards may be conducted at other VA healthcare facilities.

- O. Provides oversight and guidance for fee basis/contractual services.
- P. Annually review and makes recommendations for approval of the Service Line-Specific privilege lists.

3. Meetings:

- A. Regular Meetings: Regular meetings of the MEC shall be held at least monthly (at least 10 meetings per year). The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chairmen of the various committees of the Medical Staff shall attend regular meetings of the MEC when necessary to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the MEC.
- B. Emergency Meetings: Emergency meetings of the MEC may be called by the Chief of Staff to address any issue which requires action of the Committee prior to the next meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the MEC, the Fargo VA HCS Director, as the Governing Body, or Acting Chief of Staff, may call an emergency meeting of the Committee.
- C. Meeting Notice: All MEC members shall be provided at least one day advance written notice of the time, date, and place of each regular meeting and reasonable notice, oral or written, of each emergency meeting.
- D. Agenda: The Chief of Staff, or in his absence, such other person as provided by these Bylaws, shall chair meetings of the MEC. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to each committee meeting.
- E. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the MEC shall be a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present. The majority of the voting members must be fully licensed doctors of medicine or osteopathy. For urgent matters, the Medical Executive Committee may vote electronically. The results of the electronic vote will be provided at the following MEC meeting.
- F. Minutes: Written minutes shall be made and kept on all meetings of the MEC, and shall be open to inspection by Providers who hold membership or privileges on the Medical Staff.
- G. Communication of Action: The Chair at a meeting of the MEC at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.

Section 5.03 Committees of the Medical Staff

1. Standing Committees: Physicians, dentists and podiatrists will serve on the following medical center committees: Blood Utilization Review, Pharmacy and Therapeutics, Organizational Performance Council, Peer Review Committee, and other committees as determined by the medical center in accordance with local, national and oversight body requirements.

2. Credentials Committee:

A. Charge: Make recommendations to the Fargo VA HCS Director regarding the credentialing and privileging of providers eligible for appointment to the medical staff. Review credentials and delineate individual clinical privileges for medical staff, and review credentials and approve Scopes of Practice of mid-level providers, at the time of initial appointment and at two-year renewal. Review Ongoing Professional Practice Evaluation (OPPE) data at six month intervals, including at time of recredentialing. Review credentials and approve Board Actions (VA Form 10-2543) for initial appointments. Request evaluations of licensed independent providers when there is doubt about an applicant's ability to perform requested privileges. Review Focused Professional Practice Evaluation (FPPE) on all new providers, with addition of new privilege or procedure, and when a trigger occurs. Make recommendation with regard to continuation of the FPPE monitor. Electronic vote of Credentials Committee members may be taken when urgent matters require action between meetings. The results of the electronic vote will be provided at the next meeting of the Credentials Committee. When recommendations regarding clinical privileges result in an adverse decision regarding reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment and services; due process requirements will be followed in accordance with VHA Handbook 1100.19, *Credentialing and Privileging*.

B. Composition:

Chief of Staff –Chair

Associate Chief of Staff, Mental Health SL

Associate Chief of Staff, Primary Care & Specialty Medicine SL

Associate Chief of Staff, Dentistry

Associate Chief of Staff, Surgery and Specialty Care SL

Associate Chief of Staff, Extended Care & Rehabilitation (EC&R)

Associate Director for Patient Care/Nurse Executive

Mid-Level Provider appointed by the Chief of Staff for a two-year term

Member at Large (voting member of the medical staff) appointed by the Chief of Staff for a two-year term)

1) Non-voting members include: the Administrative Officer to the Chief of Staff, Personnel Management Specialists, Medical Staff Coordinator and Medical Staff Credentialer.

2) Meetings: Monthly

3. Pharmacy and Therapeutics Committee:

A. Charge: Recommend professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to pharmaceuticals; recommend programs designed to meet the needs of the professional staff of the HCS for complete current information on matters related to pharmaceuticals and current pharmaceutical practices.

B. Composition: Members of Medical, Nursing, Pharmacy, and Administrative Staffs.

C. Meetings: Monthly

4. Peer Review Committee:

A. Charge: The Peer Review Committee conducts the final review of all completed protected peer reviews. The Committee is responsible for ensuring consistency, reliability, and validity in the protected peer review process and results. It also provides a multi-disciplinary review environment, whereby results of protected peer reviews continually contribute to improving the overall quality of health care processes and outcomes and the utilization of health care resources at Fargo VA Health Care System (VAHCS).

B. Composition: Members of Medical and Nursing staffs.

C. Meetings: Monthly

5. Consult Management Committee:

A. Formulate and implement consult policies, identify improvement opportunities, monitor, analyze and address consult management. Respond to data requests and survey action plans.

B. Composition: Multidisciplinary representation from service lines, HIMS, CACs, NVCC, and Business Office.

C. Meetings: Monthly

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, but no longer than fourteen (14) days from the conclusion of the meeting.

2. All committees provide appropriate and timely feedback to the Service Lines/Services relating to all information regarding the Service Line/Service and its providers.
3. Each committee shall review and forward to the MEC a synopsis of any subcommittee and/or workgroup findings.

Section 5.05 Establishment of Committees

1. The MEC or COS may, by resolution and upon approval of the Fargo VA HCS Director, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions.
2. The MEC may, by resolution and upon approval of the Fargo VA HCS 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 as a whole are held on a quarterly basis (4 times per year) or at the call of the Chief of Staff. A record of attendance and minutes 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 Fargo VA HCS Director or the MEC. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Fargo VA HCS Director in writing and stating the reason(s) for the request in no less than five (5) workdays.
3. Quorum: For purposes of Medical Staff business, a quorum is defined as thirty voting members in attendance.
4. Meeting Attendance: Members of the Organized Medical Staff are required to attend two (2) of the regular Medical Staff meetings per year and a majority of Service-level staff meetings unless specifically excused by the Service Line ACOS for appropriate reasons; e.g. illness, leave or clinical requirements.
5. Facility Based Committees: Members of the organized Medical Staff are required to attend those meetings related to their leadership or staff functions within the facility. Examples include but are not limited to Blood Transfusion Committee, Radiation Safety Committee, Research and Development Committee.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. Independent Entity: The Fargo VA Health Care System is an independent entity, granting privileges to the medical staff through the recommendation of the

Credentials Committee to the MEC and the Fargo VA HCS Director as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Mid-Level Provider, and Associated Health Provider reappointments may not exceed two (2) years, minus one day from the date of last appointment or reappointment date. Medical Staff, Mid-Level and Associated Health Providers must practice under their privileges or scope of practice.

2. Credentials Review: All Licensed Independent Providers (LIP), and all Mid-Level and Associated Health Providers who hold clinical privileges or scopes of practice will be subjected to full credentials review at the time of their initial appointment, every two (2) years thereafter and after a break in service of more than 30 days. Credentials that are subject to change (such as state licenses) during leaves of absence shall be reviewed at the time the individual returns to duty. Providers 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 Provider from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Provider will update the credentialing file to "Current Status."
 - B. After verification of the updated information is documented, the information will be referred to the Provider's Service Line/Service ACOS and then forwarded to the Credentials Committee/MEC for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Line/Service ACOS and Credentials Committee to put an FPPE in place to support current competence. The Fargo VA HCS 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 Provider must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.
 - D. In those instances where the Provider was not providing clinical care while on active duty, the Provider in cooperation with the Service Line ACOS 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 not less than 90 nor more than 180 days. These providers may be returned to a pay status, but may or may not be in direct patient care at the discretion of the Fargo VA HCS Director.
4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:

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

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

5. Initial Focused Professional Practice Evaluation:

A. The initial focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege-specific competence of a Provider who does not have documented evidence of competently performing the requested privilege. This occurs with a new Provider or an existing Provider who requests a new privilege. The performance monitoring process is defined by each Service Line/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 or when such internal or external monitoring may be discontinued.

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(l), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations.
- 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. The COS will convene summary review board to determine whether provider should be terminated or allowed to continue with probation period.

6. Ongoing Professional Practice Evaluation:

A. The on-going monitoring of privileged providers 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. Failure to meet the expectations or metrics addressed in the OPPE may require intervention by the medical staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for medical staff leadership. Each Service Line/Service ACOS should consider what hospital, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The American Board of

Medical Specialties or American Osteopathic Association Maintenance of Certification is not sufficient in and of itself to meet the requirements of OPPE. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, may be incorporated into the on-going monitoring process. Data must be provider specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate. OPPE data will be forwarded to the Credentials Committee for review every six (6) months, including at time of recredentialing.

- B. In those instances where a provider does not meet the OPPE established criteria, the Service Line Director has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a Service Line/Service ACOS recommending the renewal of privileges, but the Service Line/Service ACOS must clearly document the basis for the recommendation of renewal of privileges. Information resulting from the OPPE is used to determine whether to continue, limit, or revoke existing privilege(s).
- C. The Medical Executive Committee (MEC) must consider all information available, including the Service Line ACOS's recommendation and reasons for renewal regardless of whether OPPE/FPPE criteria have not been met, prior to making their recommendation for the granting of privileges to the Fargo VA HCS Director. This deliberation must be clearly documented in the minutes.
- D. The Fargo VA HCS Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

Section 7.02 Application Procedures

1. **Completed Application:** Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines found in VHA Handbook 1100.19. The applicant must be forthcoming, honest and truthful (1100.19 page 9). 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 Provider says the information provided is factually incorrect.
 - A. Documentation specified in Article III, Section 2, Qualifications for Medical Staff Membership, which must be submitted include :
 - 1) At least one Active, Current, Full, and Unrestricted State License.
 - 2) Education.
 - 3) Relevant training and/or experience.
 - 4) Evidence of current professional competence and conduct.

- 5) Evidence of the ability to perform privileges requested (Physical and Mental health status).
 - 6) English language proficiency.
 - 7) Professional liability insurance (contractors only).
 - 8) Evidence of BLS Certification using criteria established by the American Heart Association unless a waiver has been granted.
 - 9) To qualify for moderate sedation and airway management privileges, the Provider will have specific, approved clinical privileges and will acknowledge that they have received a copy of the Conscious Sedation policy and agree to the guidelines outlined in the policy.
- B. U.S. Citizenship: Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, Providers 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 Customs Enforcement 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 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 Fargo VA HCS Director may require additional information.
- D. Previous Employment: The candidate must report health care institutions or other organizations where the Provider is/has been appointed, utilized or employed (held a professional appointment), for the past three appointments or for maximum of past ten (10) years 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 but not limited to suspension, revocation, limitations, or voluntary surrender.
- E. DEA (if applicable) Registration: The candidate must have a valid DEA Certificate.
- 1) Candidate must report any previously successful or currently pending challenges to, or the voluntary relinquishment of, the Provider's DEA registration.
- F. Sanctions or Limitations: The candidate must report 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 Provider has been suspended, revoked, voluntarily surrendered, or not renewed.

- G. Liability Claims History: The candidate must report the status (Open, Pending, Closed, Dismissed, etc.) of any claims made against the Provider in the practice of any health occupation including final judgments or settlements, if available.
 - H. Loss of Privileges: The Candidate must report voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at any other health care facility.
 - I. Release of Information: The Candidate must provide 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: The candidate must report pending challenges against the Provider by any governmental agency, hospital, licensing agency, professional group, or society.
2. Primary Source Verification: In accordance with VHA Handbook 1100.19 Credentialing and Privileging, and VA Handbook 5005, Part II, Chapter 3, the facility will obtain primary source verification of:
- A. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article VIII, Section 8.02.
 - B. Verification of current or most recent clinical privileges held, if available.
 - C. Verification of status of all licenses current and previously held by the applicant.
 - D. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.
 - E. Evidence and verification of board certification or eligibility, if applicable.
 - F. Verification of education credentials used to qualify for appointment including all postgraduate training.
 - G. Evidence of registration with the National Providers Data Bank (NPDB) Continuous Query Update, for all members of the Medical Staff and those Providers 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 will be obtained from the State licensing board for all disciplinary actions as well as a statement from the Provider.
 - I. Attestation and certification that no health problems exist that could affect his/her practice.
 - J. Evidence and verification of the status of any alleged or confirmed malpractice.

- K. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, and Rules and Regulations, for the facility to which the application is being made.
3. The applicant's attestation to the accuracy and completeness of the information submitted.
 4. Burden of Proof: The applicant has the burden of obtaining and producing all needed information for a proper evaluation of the applicant's professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of the request to the applicant may serve as a basis for denial of the credentialing and privileging application.
 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. The Service Line/Service Recommendation: The Associate Chief of Staff or Medical Director for the Service Line/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 Line/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 Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the MEC if the response from the NPDB continuous query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three (3) or more medical malpractice payments, (b) a single medical malpractice payment of \$550,000 or more, or (c) two (2) medical malpractice payments totaling \$1,000,000 or more. The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Line/Service ACOS Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.
3. MEC Recommendation: MEC 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. Fargo VA HCS Director Action: Recommended appointments to the Medical Staff should be acted upon by the Fargo VA HCS Director within 30 work days of receipt

of a fully complete application, including all required verifications, references and recommendations from the appropriate Associate Chief of Staff or Medical Director of the Service Line/Service and MEC.

5. **Applicant Informed of Status:** Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or return of the application because of inadequate information within 30 days of the Action by the Fargo VA HCS Director.

Section 7.04 Credentials Evaluation and Maintenance

1. **Evaluation of Competence:** A Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the Provider applying for clinical privileges has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within the 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.
3. **Maintenance of Files:** A complete and current Credentialing and Privileging (C&P) 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. An FPPE, implemented at time of initial appointment, will be based on the Provider’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 Provider by the Associate Chief of Staff or Medical Director for the Service Line/Service.
 - A. An FPPE at the time of request for additional privileges will be for a specified period of time, number of procedures, and/or chart review to be set by the Associate Chief of Staff or Medical Director for Service Line/Service.
 - B. An FPPE initiated by a “for-cause” event will be set by the Associate Chief of Staff or Medical Director for the Service Line/Service. FPPE for cause is utilized

when there is concern regarding competence and the care being rendered to patients, and may require direct supervision and appropriate action on privileges i.e., summary suspension.

C. 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.
- 5) Measure utilized to resolve performance issues will be consistently implemented.

D. If at any time the Associate Chief of Staff or Medical Director for the Service Line/Service or designee cannot determine the competence of the Provider being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Associate Chief of Staff or Medical Director for the Service Line/Service:

- 1) Extension of FPPE review period.
- 2) Modification of FPPE criteria.
- 3) FPPE related privileges (initial or additional) may be revoked (appropriate due process will be afforded to the Provider).
- 4) Termination of all existing privileges (appropriate due process will be afforded to the Provider and will be appropriately terminated and reported).

Section 7.05 Local/VISN-Level Compensation Panels

Local or VISN-level Compensation Panels recommend the appropriate pay table, tier level and market pay amount for individual medical staff members, as outlined in VA Handbook 5007, Part IX/21. Appointment actions recommended by the Credentialing Committee 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 Provider who has clinical privileges. Reappraisal is initiated by the Provider's Associate Chief of Staff or Medical Director for the Service Line/Service at the time of a request by the Provider 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 Provider's performance.
 - B. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.

3. 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 Credentials Committee and MEC. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (VA Handbook 1100.19 page 7).
4. A Provider may request modification or addition of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Associate Chief of Staff or Medical Director for the Service Line/Service.
5. Associated Health and Mid-Level Providers who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.
6. Requirements and processes for requesting and granting privileges are the same for all Providers who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
7. Providers 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 Associate Chiefs of Staff or Medical Directors for the Service Line/Service must recommend the practice.
8. Exercise of clinical privileges within any SL/Service is subject to the rules of that Service Line/Service and to the authority of that Associate Chief of Staff or Medical Director for the Service Line/Service.
9. 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.
10. Telemedicine: All Providers involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.
11. Teleconsultation: All Providers providing teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. **Burden of Proof:** When additional information is needed, the Provider 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 Provider is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of the request may result in denial of clinical privileges.
2. **Requests in Writing:** All requests for clinical privileges must be made in writing by the Provider, and include a statement of the specific privileges being requested in a format approved by the Medical Staff.
3. **Credentialing Application:** The Provider applying for initial clinical privileges must submit a complete application for privileges that includes:
 - A. Complete appointment information as outlined in Section 2 of Article VI.
 - B. Application for clinical privileges as outlined in this Article.
 - C. Evidence of professional training and experience in support of privileges requested.
 - D. A statement of the Provider's physical and mental health status as it relates to Provider's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. A statement of the current status of all licenses and certifications held.
 - E. 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.
 - F. Names of other hospitals at which privileges are held and requests for copies of current privileges held.
 - G. 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.
 - H. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association.
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. The attestation is signed and recorded in the Provider's VetPro file.
5. **Moderate Sedation and Airway Management:** To qualify for moderate sedation and airway management privileges, the Provider must have specific, approved clinical privileges and acknowledge that he/she has received a copy of the Moderate

Sedation and Out of the OR Airway Management policies and agree to the guidelines outlined in the policies.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

1. **Application:** The Provider applying for renewal of clinical privileges must submit the following information:
 - A. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Providers are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Line/Service Associate Chief of Staff prior to formal submission of privilege requests.
 - B. Supporting documentation of professional training and/or experience which may not have been previously submitted.
 - C. A statement of the Provider's physical and mental health status as it relates to Provider's ability to function within privileges. This must be confirmed by a physician acceptable to the MEC. Reasonable evidence of health status may be required by the MEC.
 - D. Documentation of continuing medical education related to area and scope of clinical privileges, (consistent with minimum state licensure requirements). 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 by credentialing staff. This applies to licenses held in multiple states for the same professional discipline or practice.
 - E. 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) business days of the adverse action.
 - F. 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.
 - G. Names of other hospitals or facilities at which privileges are held.
2. **Verification:** Before granting clinical privileges, the Credentialing and Privileging Office will ensure that the following information is on file and verified with primary sources, as applicable:
 - A. Current and previously held licenses in all states.
 - B. Current and previously held DEA.

- C. State CDS registration (if applicable).
- D. NPDB Continuous Query Registration.
- E. FSMB query.
- F. Physical and mental health status information from applicant.
- G. Physical and mental health status confirmation.
- H. Professional competence information from peers and Associate Chief of Staff for the Service Line, based on results of ongoing professional practice monitoring and FPPE.
- I. Continuing education to meet any requirements for privileges requested.
- J. Board certifications, if applicable.

Section 8.04 Processing an Increase or Modification of Privileges

1. A Provider's request for modification of or addition to, existing clinical privileges is initiated by the Provider's submission of a formal request for the desired change(s) with full documentation to support the change to the Associate Chief of Staff for the Service Line/Service. 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 must be reviewed prior to rendering a decision.
4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Credentials Committee and the MEC followed by approval of the Fargo VA HCS Director.

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

1. Peer recommendations from practitioners in the same professional discipline as the applicant who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.
2. The Associate Chief of Staff for the Service Line/Service where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation to the Credentials Committee regarding the request for clinical privileges.
 - A. Recommendations for initial, renewal or modification of privileges are based on a determination that the applicant meets the criteria for appointment and clinical privileges for the Service Line/Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six (6) core competencies in making recommendations for appointment. The same six (6) core competencies are considered for both initial appointment and reappointment. The core competencies are:

- 1) Medical/Clinical knowledge (education competency).
 - 2) Interpersonal and Communication skills (documentation; patient satisfaction).
 - 3) Professionalism (personal qualities).
 - 4) Patient Care (clinical competency).
 - 5) Practice-based Learning & Improvement (research and development).
 - 6) System-based Practice (access to care).
3. The MEC recommends granting clinical privileges to the Fargo VA HCS Director based on the each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. The Credentials Committee completes the initial review and recommendation and forwards to MEC for reviewed and approval.
 4. Clinical privileges must be acted upon by the Fargo VA HCS Director within 30 calendar days of receipt of the MEC recommendation to appoint. The Fargo VA HCS Director's action must be verified with an original signature.
 5. Originals of approved clinical privileges are placed in the individual Provider's Credentialing and Privileging File. A copy of approved privileges is given to the Provider and is readily available to appropriate staff for comparison with Provider procedural and prescribing practices.

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 60 calendar days) by the Fargo VA HCS Director or Acting Fargo VA HCS 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 Provider'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 voluntary limitation, reduction, denial, or loss of clinical privileges.
 - 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:**

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

D. The recommendation by the delegated subcommittee of the Medical Executive Committee must be acted upon by the Facility Director.

E. Full credentialing must be completed within 60 calendar days of the date of the Director's/Governing Body's signature and presented to the Medical Executive Committee for ratification.

3. Emergency Care: Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.
4. Disaster Privileges: As described in the Facility's Emergency Management Plan:
 - A. In the event of the implementation of the organization-wide disaster management plan, Disaster Privileges may be approved by the Fargo VA HCS Director, Chief of Staff or designee, if it is determined that it is not possible to handle the influx of patients with the existing Providers. The individual must present, at a minimum, a valid government issued photo identification issued by a state or federal agency; e.g. drivers license, passport, or a current picture hospital identification card, and at least one of the following:
 - 1) Evidence of current license to practice (NOTE: Primary source verification of the license is to begin as soon as the immediate situation is under control, and to be completed within 72 hours from the time the volunteer Provider presents to the organization); or
 - 2) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
 - 3) Identification that the individual has been granted authority to render patient care in emergency circumstances by a Federal, State, or municipal entity; or
 - 4) Personal attestation by current medical center or medical staff member (s) regarding Provider identity.
 - 5) The documentation will service as credentials verification for a period not to exceed ten (10) calendar days or length of the disaster, whichever is shorter. Primary source verification of licensure will be obtained within seventy-two (72) hours after the disaster is under control, or as soon as possible in extraordinary circumstances.
 - 6) In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the ten (10) calendar days or the length of the declared disaster, whichever is shorter, noted in paragraph 5) above, the Provider must be converted to Temporary Privileges in accordance with VHA Handbook 1100.19, Credentialing and Privileging, for a period not to exceed 60 working days.
 - 7) An assigned, appropriately credentialed and privileged physician will oversee the professional practice of each volunteer provider.
 - 8) The quality of the care and service rendered by each volunteer Provider with Disaster Privileges must be evaluated by the Chief of Staff no later than after 72 hours after privileges have been granted or as indicated and a determination made as to whether or not the Provider will be permitted to

continue providing services. The decision of the Chief of Staff is final and not subject to appeal.

5. Inactivation of Privileges: The inactivation of privileges occurs when a Provider is not an actively practicing member of the medical staff for greater than 30 days, such as extended sick leave or sabbatical with or without clinical practice while on sabbatical.
 - A. When the Provider returns to the Facility, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be verified again. Inactivation of privileges may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.
 - B. At the time of inactivation of privileges, including separation from the medical staff, the Fargo VA HCS Director ensures that within seven (7) calendar days of the date of separation, information is received suggesting that Provider 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.
 - C. Deployment and Activation Privilege Status: In those instances where a Provider is called to active duty, the Provider'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 Provider before deployment.
 - D. The Medical Staff Office requests that a Provider returning from active duty communicate with them as soon as possible upon returning to the area.
 - E. After the electronic credentials file has been reopened for credentialing, the Provider must update the licensure information, health status, and professional activities while on active duty.
 - F. The credentials file must be brought to a verified status. If the Provider performed clinical work while on active duty, an attempt is made to confirm the type of duties, the Provider's physical and mental ability to perform these duties, and the quality of the work. This information must be documented.
 - G. The verified credentials, the Provider's request for returning the privileges to an Active Status, and the Service Line/Service Associate Chief of Staff's recommendation are presented to the Credentials Committee and the MEC for review and action. The documents reviewed, the determination, and the rationale for the determination from the Credentials Committee and the MEC is documented and forwarded to the Fargo VA HCS Director for recommendation and approval of restoring the Provider's privileges to Current and Active Status from Deployment and/or Activation Status.
 - H. In those instances when the Provider'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.

- I. In those instances where the privileges lapsed during the call to active duty, the Provider will provide additional references for verification and facility staff will perform all verifications required for reappointment.
- J. In those instances where the Provider was not providing clinical care while on active duty, the Associate Chief of Staff for the Service Line/Service must consider whether a request for modification of the privileges held prior to the call to active duty should be submitted. If approved by the Credentials Committee, the modification of privileges shall be for a period of no less than 30 calendar days.
- K. If the file cannot be brought to a verified status and therefore the Provider's privileges cannot be restored by the Fargo VA HCS Director, the Provider can request and be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days. During that time, the credentialing and privileging process must be completed. 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 60 calendar days.

Section 8.07 Medical Assessment

1. A medical history and physical examination is completed within 30 days before admission or registration, the physician 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 a 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 Provider 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 Provider may be requested by the Associate Chief of Staff for the Service Line/Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Fargo VA HCS 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 will promptly notify the Fargo VA HCS Director in writing of the receipt of all requests investigation. 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 non-protected peer review, 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 protected peer review, administrative review or investigation process. If the person under review is an employee, then the processes must also follow VA Directive 5021.

2. Fact Finding Process: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article, a fact finding process will be implemented. The Chief of Staff will appoint a subgroup of the Professional Standards board that will conduct the investigation and submit a written report to the entire Board. This fact-finding process should be completed within 30 days or documentation must be submitted to the Chief of Staff as to why that was not possible. If the results of the fact-finding process indicate that there is a reasonable cause to believe that the behaviors, activities and/or professional conduct of the Provider are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by a Summary Review Board.
3. Review by a Summary Review Board: A Summary Review Board is appointed to investigate the charges and make a report of the investigation to the voting members of the MEC. The Summary Review Board must submit its report and request for corrective action within fourteen (14) calendar days from the date of its constitution. The Provider being investigated has an opportunity to meet with the Summary Review Board to discuss, explain or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation by the Summary Review Board is an administrative matter and not an adversarial Hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations reported to the voting members of the MEC.

4. **MEC Action:** Only voting members of the MEC are permitted to participate in the hearing and action on the report by the Summary Review Board. The voting members of the MEC must convene and act on the request within fourteen (14) calendar days. If the action being considered by the voting members of the MEC involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Provider is permitted to meet with the voting MEC prior to the committee's action on such request. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. A record of such proceeding is made by the MEC.
 - A. The MEC may reject or modify the recommendations; 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 Provider's staff membership be suspended or revoked.
 - B. Any recommendation by the MEC for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Provider to the rights set forth in Article X of these Bylaws.
 - C. Reduction of privileges may include, but not be limited to, functioning under supervision¹, 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 Fargo VA HCS Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, a portion or all of a Provider's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Fargo VA HCS Director. Following the Summary Suspension:
 - A. The Chief of Staff will convene a Summary Review Board to investigate the matter, meet with the Provider, if requested, and make a report thereof to the MEC within fourteen (14) days after the effective date of the Summary Suspension.
 - B. A notice of summary suspension will be sent from the Fargo VA HCS Director to the provider to include a discussion of the reason for suspension, notice to the individual of all due process rights, and the statement that if a final action is taken, based on professional competence or professional conduct grounds, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB-HIPDB. Summary suspension pending comprehensive

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

review and due process, as outlined VHA Handbook 1100.19, *Credentialing and Privileging*, is not reportable to the NPDB-HIPDB.

- C. When privileges are summarily suspended, a comprehensive review of the reason for summary suspension must be accomplished within fourteen (14) calendar days, with formal recommendation for reduction or revocation of clinical privileges forwarded to the Fargo VA HCS Director for consideration and action. The Fargo VA HCS Director must make a decision within five (5) working days of receipt of the recommendations.
 - D. Proceeding to the reduction or revocation of privileges requires appropriate due process. Guidance should be sought from Regional Counsel and Human Resources to ensure due process is afforded.
 - E. Immediately upon the imposition of a Summary Suspension, the Associate Chief of Staff for the Service Line/Service or the Chief of Staff will arrange alternate medical coverage for the patients of the suspended Provider.
6. Automatic Suspension of Privileges: An Automatic Suspension occurs immediately, upon the occurrence of certain specific events.
- A. The medical staff membership and clinical privileges of any Provider with delineated clinical privileges shall be automatically suspended if any of the following occurs:
 - 1) The Provider is being investigated, indicted or convicted of a misdemeanor or felony that could impact the quality and safety of patient care.
 - 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 Provider is being investigated for fraudulent use of the Government credit card.
 - 4) Failure to maintain the mandatory requirements for membership on the medical staff.
 - B. The Chief of Staff will convene a Summary Review Board to investigate the matter and make a report thereof to the MEC within fourteen (14) days after the effective date of the Automatic Suspension.
 - C. Immediately upon the occurrence of an Automatic Suspension, the Associate Chief of Staff for the Service Line/Service or the Chief of Staff will arrange alternate medical coverage for the patients of the suspended Provider.
 - D. If there are more than three automatic suspensions of privileges in one calendar year, or more than 20 days of automatic suspension in one calendar year, a thorough assessment of the need for the Provider's services must be performed and documented and appropriate action taken.
7. Actions Not Constituting Corrective Action: The Summary Review Board 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 Provider to appear at an interview or conference before the Credentials Committee, any ad hoc investigating committee, the Chief of Staff, or any other committee or sub-committee with appropriate jurisdiction in connection with any investigation prior to a proposed adverse recommendation or action;
- D. The failure to obtain or maintain any other mandatory requirement for Medical Staff membership;
- E. The imposition of proctoring or observation on a Medical Staff member which does not restrict clinical privileges or the delivery of professional services to patients;
- F. Corrective counseling;
- G. A recommendation that the Provider 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 Provider, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Provider.

ARTICLE X FAIR HEARING AND APPELLATE REVIEW

1. Reduction or revocation of Privileges:

- A. Prior to any action or decision by the Fargo VA HCS Director regarding reduction or revocation of privileges, the Provider 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 Provider's right to be represented by counsel or a representative of the individual's choice, throughout the proceedings.
- B. The Provider will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Provider may respond in writing to the Chief of Staff's written notice of intent. Said response must occur and be received by the Chief of Staff within ten (10) workdays of the Chief of Staff's written notice. If requested by the Provider, the Chief of Staff may grant an extension for a brief period, normally not to exceed ten (10) additional workdays except in extraordinary circumstances.
- C. Information will be forwarded to the Fargo VA HCS Director for decision. The Director will make a decision on the basis of the record. If the Provider disagrees with the Fargo VA HCS Director's decision, a hearing may be requested. The

Provider must submit the request for a hearing within five (5) workdays after receipt of decision of the Fargo VA HCS Director.

2. Convening a Panel: The Fargo VA HCS Director must appoint a review panel of three unbiased professionals, within five (5) workdays after receipt of the Provider'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 as the provider. 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 or revocation of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:
 - A. The Provider must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.
 - B. During such hearing, the Provider has the right to:
 - 1) Be present throughout the evidentiary proceedings.
 - 2) Be represented by an attorney or other representative.
 - a) The rules for the conduct of the hearing shall be determined by the Panel utilizing the established Disciplinary Appeals Board structure as a model.
 - b) All proceedings will be recorded by a court reporter for transcription and distribution to the Board and made available to the Provider for purchase.
3. In cases involving reduction of privileges, a determination must be made during the hearing process by the Board as to whether disciplinary action should be initiated.
4. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the Fargo VA HCS Director for extraordinary circumstances or cause.
 - A. The panel's report, including findings and recommendations, must be forwarded to the Fargo VA HCS Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.
 - B. The Fargo VA HCS Director must issue a written decision within ten (10) workdays of the date of receipt of the panel's report. If the Provider's privileges are reduced or revoked, the written decision must indicate the reason(s). The signature of the Fargo VA HCS Director constitutes a final action and the reduction is reportable to the NPDB.
 - C. If the Provider wishes to appeal the Director's decision, the Provider may appeal to the VISN Director within five (5) workdays of receipt of the Fargo VA HCS Director's decision. This appeal option will not delay the submission of the NPDB report. If the Fargo VA HCS Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.
 - D. The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the Provider's appeal.

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

E. The hearing panel chair shall do the following:

- 1) 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.
- 2) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.
- 3) Maintain decorum throughout the hearing.
- 4) Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
- 5) 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.
- 6) Hearing of argument by counsel on procedural points must be conducted outside the presence of the hearing panel.
- 7) Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

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

- 1) 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 Fargo VA HCS Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Fargo VA HCS Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.
- 2) The Fargo VA HCS Director will issue a written decision within ten (10) workdays of the day of receipt of the panel's report. If the Provider's privileges are reduced, the written decision will indicate the reason(s) for the change.
- 3) The Provider may submit a written appeal to the VISN Director within five (5) workdays of receipt of the Director's decision.
- 4) The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the Provider's appeal. The decision of the VISN Director is not subject to further appeal.

- 5) A Provider who does not request a review panel hearing but who disagrees with the Fargo VA HCS Director's decision may submit a written appeal to the appropriate VISN Director within five workdays after receipt of the Fargo VA HCS Director's decision.
- 6) The review panel hearing defined in paragraph 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 hearing record.
- 7) If a Provider surrenders or voluntarily accepts a reduction or revocation of his/her clinical privileges, for a period of greater than 30 days, resigns or retires from his/her medical staff position with the Department of Veterans Affairs while under investigation, such action must be reported without further review or due process to the NPDB and the appropriate state licensing boards.

G. Revocation of Privileges:

Proposed action taken to revoke a Provider'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.
- 3) For temporary employees appointed under 38 U.S.C 7405(A) (1), the proposed revocation will be combined with an action to terminate the appointment as contained in VA Handbook 5021.
- 4) 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 Provider 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 MEC for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Provider to the rights set forth in Article X of these Bylaws.

H. Reporting to the National Provider Data Bank²:

- 1) Tort (“malpractice”) claims are filed against the United States Government, not individual Providers. There is no direct financial liability for named or involved Providers. 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) 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 Providers 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 VA Provider in order to meet reporting requirements.
- 3) Providers 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.
- 4) Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff’s case by the Office of Medical-legal Affairs when a tort claim settlement is submitted for review.
- 5) VA only reports adverse privileging actions that affect the clinical privileges of Physician and Dentists after a professional review action or if the Provider surrenders or voluntarily relinquish clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Provider for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4 The notice of summary suspension to the Provider must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension if greater than 30 days will be reported.

I. Reporting to State Licensing Boards: The Fargo VA HCS Director has a responsibility to report to state licensing boards 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.

J. 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. This action effectively suspends privileges, during the pendency of any proposed reduction or revocation of privileges or discharge, separation, or termination proceedings. Further, the Fargo VA HCS Director, on

² Reference VHA Handbook 1100.17.

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 the authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of the VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

ARTICLE XI RULES AND REGULATIONS

1. Medical Staff Rules and Regulations may be adopted as necessary to implement specifics of the general principles of conduct found in these Bylaws. Such Rules and Regulations may also 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. Rules and Regulations may be adopted, amended, repealed or added by a majority vote at a meeting of the MEC. Medical Staff Rules and Regulations must be approved by the Fargo VA HCS 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. Proposed amendments must be approved by the MEC prior to the submission of the recommended amendment to the Fargo VA HCS Director. Amendments to the bylaws are adopted and voted on by the Organized Medical Staff as a whole and then approved by the Fargo VA HCS Director. The Bylaws are amended and adopted by a majority vote of 60% of the active medical staff.

2. The Medical Executive Committee may adopt urgent amendments to the Rules and Regulations that are deemed necessary for legal or regulatory compliance. After adoption, these urgent amendments to the Rules and Regulations will be communicated back to the Organized Medical Staff for review at their next scheduled meeting or by an emergency meeting called by the Chief of Staff. If there is no modification to the amendment to the Rules and Regulations, 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 the Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
4. All changes to the Bylaws require action by both the Organized Medical Staff and Fargo VA HCS Director. Neither may unilaterally amend the Bylaws.
5. Changes are effective when approved by the Fargo VA HCS Director.

ARTICLE XIII ADOPTION

1. These Bylaws shall be adopted upon recommendation of the Organized Medical Staff at any regular or special meeting of the Organized Medical Staff at which a quorum is present. They shall replace any previous Bylaws and shall become effective when approved by the HCS Director.
2. 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.


RECOMMENDED


 BRETON M. WEINTRAUB, MD, FACP
 Chief of Staff


 Date




 LAVONNE LIVERSAGE, FACHE
 Health Care System Director


 Date

MEDICAL STAFF RULES

1. GENERAL

- A. The Rules describe the roles and responsibilities of members of the Medical Staff in the care of patients.
- B. Rules of Departments or Services will not conflict with each other, rules and policies of the Medical Staff, or with requirements of the Governing Body.
- C. The Medical Staff as a whole shall hold meetings at least annually.
- D. The MEC serves as the executive committee of the Medical Staff and between the annual meetings, acts in their behalf. The MEC 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 results of ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion and participation by medical staff (and responsible parties) of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.
- F. Information used in protected peer review as referenced in Article IX, cannot be used when making adverse privileging decisions.

2. PATIENT RIGHTS

- A. Patient's Rights and Responsibilities: This Organization supports the rights of each patient and publishes policy and procedures to address rights including each of the following:
 - 1) Reasonable response to requests and need for service within capacity, mission, laws and regulations.
 - 2) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
 - 3) Collaboration with the physician in matters regarding personal health care.
 - 4) Pain management including assessment, treatment and education.
 - 5) Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.
 - 6) Formulation of advance directives and appointment of surrogate to make health care decisions (38 CFR17.32).
 - 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 *the Chief of Staff* to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available).
- 14) Foregoing or withdrawing life-sustaining treatment including resuscitation.
- 15) Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.
- 16) Living Will, Advance Directives, and Informed Consent (38 CFR 17.32)
- 17) 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.
- 18) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with, as appropriate, other members of the treatment team (38 USC sections 7331).
- 19) 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.
- 20) 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.
- 21) 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.

22) 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.
- 2) The attending Staff Physician is responsible for the preparation and completion of a complete medical record for each patient. This record shall include a medical examination, an 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.
- 3) A medical history and physical examination must be completed within 30 days before admission. However, the provider must complete and document an updated examination of the patient within 24 hours after admission, 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 required content of any complete and focused history and physical examination is delineated below.

Medical Assessment of the patient shall include:

- a) 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
- 4) The staff physician responsible for the patient must sign the admission note if it is prepared by a resident, inter, or Mid-level Provider. Alternatively, he/she may:

- a) make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" or
- b) make whatever comments he/she thinks the case warrants, or prepare a complete admission within twenty-four (24) hours of admission to the facility. CLC admission notes must be completed with forty-eight (48) hours of admission. A resident, intern, or Mid-Level Provider admission workup will be retained, but the official workup will contain the responsible medical Staff physician's approval signature. All resident documentation will follow procedures outlined in the VHA Handbook 1400.1, Resident Supervision.
- c) Food and nutrition products are administered only on the prescription or order of a Medical Staff member, an authorized house staff member, or other individual who has been granted authority to write such prescriptions or orders, within their scope of practice.
- d) Progress note entries should be identified as to the type of entry being made, (e.g., Resident Note, Attending Note, Off Service Note, etc.). The Attending Note must be signed by the Attending physician.
- e) Progress notes will be written by the Provider at least once daily on all patients. Progress notes are written for all patients seen for outpatient care by the responsible medical staff.
- f) Evidence of required supervision of all care by the attending physician shall be documented in the medical record, the frequency of notes dependent upon the severity of the illness of the patient but no less than once per day. It is a cardinal principle that responsibility for the care of each patient lies with the staff physician to whom the patient is assigned and who supervises all care rendered by residents.
- g) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written or, at minimum, countersigned in the patient's medical record by the attending physician. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the Facility staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.
- h) Patients will not be transferred out when the Facility has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer only after authorization is given by the appropriate provider as defined in facility policy.
- i) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and

across Department and Services and between all staff members who have clinical privileges.

- j) 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 physician is desirable when in the judgment of the patient's physician:
 - a) The patient is not a good risk for operation or treatment,
 - b) The diagnosis is obscure, and/or
 - c) There is doubt as to the best therapeutic measures to be utilized.
- 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 MEC and the Credentials Committee 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 ACOS for the Service Line/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 in the medical record by the consultant or the requesting physician.

C. Discharge Planning: Discharge planning is initiated at the time of the patient's admission.

- 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 the facility only upon the written order of the Medical Staff Member. 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. CPRS prior to discharge, or within 24 hours of a death or irregular discharge for inpatients and within 72 hours for Community Living Center (CLC) patients.

2) For those patients that are discharged from CLC while absent sick in hospital (ASIH) to include VA or a Non VA facility, the summary will be dictated within 72 hours of notification of the discharge while absent sick.

3) 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 physician or dentist shall complete his/her portion of the record within thirty (30) days, including authentication.

4) When the discharge summary is completed more than 24 hours prior to discharge, a brief addendum will be required; for discharge summaries completed more than 72 hours prior discharge from CLC, a brief addendum will be required.

5) Patients from Outpatient Surgery can be discharged based upon the order of medical staff member familiar with the patient or when the medical staff member is not available, based on relevant medical staff approved criteria.

E. Autopsy

1) Autopsy services are provided through a contract with our academic affiliate, the University of North Dakota School of Medicine and Health Sciences. The availability of these services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within the facility.

2) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17.170. Whenever possible, the physician responsible for the care of the patient at the time of death will be designated to request permission from the next of kin to perform an autopsy.

3) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.170 and VHA Handbook 1106.01 Autopsy Services (which includes Criteria for assignment to medico-legal status).

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

5) Autopsy Criteria. VHA Directive 2011-019, Handbook 1106.01, 38 CFR 17.170 and facility circular PC-09 encourage 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 per VHA policy. 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 not allowed except in emergency situations.

B. Telephone orders will be accepted when the provider is not in the facility and cannot return in a timely manner and does not have ready access remotely to the EMR. 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 physician to ensure correctness. Verbal/telephone orders will be entered by the nurse or pharmacist and authenticated within the time frame specified by law and regulation.

C. Medication Orders

- 1) All drugs used in the Facility must be on the National Formulary and additions as approved by the VISN Pharmacy and Therapeutics (P&T) Committee or be Investigational Drugs that have been approved by the Research and Development Committee and the Facility P&T committee. Exceptions to the foregoing requirements may be made in use of "provisional drugs" or "non-formulary drugs" which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN level. Exceptions are based on an individual patient case by case basis.
- 2) All drugs used in the Facility will be stored and dispensed by the Pharmacy unless utilized for imaging purposes and dispensed from the pharmacy to the Imaging Department.
- 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 reentered by electronic entry into EMR 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 first medication was ordered before they expire and must be rewritten.
- 4) Outpatient Medication Orders:
 - a) All prescriptions must be entered electronically including Schedule II Controlled Substances which must be accompanied by a hard copy prescription.
 - 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 life of a single prescription will not exceed one (1) 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 physician of record, orders must be written for the new level of care and if appropriate to indicate the transfer to the new physician of record. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.
- D. Standardized Order Sets (protocols): Standardized order sets are reviewed periodically by ACOS of the Service Line/Service and modified as needed. All standardized order sets in the EMR shall be authenticated by a Medical Staff member and are to be signed for each usage by a medical staff member. All concerned personnel shall be notified of revisions to standardized order sets by the ACOS for the Service Line/Service.
- E. Investigational Drugs: Investigational drugs will be used only when approved by the Research and Development Committee and the P&T Committee. Such drugs will be administered only under approved protocol with patient informed consent, under the direct supervision and legitimate order of the authorized Principal Investigator or designated investigator.
- F. Informed Consent:
 - 1) Informed consent will be consistent with legal requirements and ethical standards, as described in facility policy RI-14, Informed Consent.
 - 2) Evidence of receipt of Informed consent, documented in the EMR is necessary before procedures or treatment for which it is required.
- G. Submission of Surgical Specimens: All tissues and objects except teeth removed at operation shall be sent to the Pathology and Laboratory Medicine Service Line for examination and pathological diagnosis.

H. Special Treatment Procedures:

- 1) DNR (Do Not Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment
 - a) A description of the role of the physician, family members and when applicable, other staff in decision.
 - b) Mechanisms for reaching decisions about withholding of resuscitative services, including mechanisms to resolve conflicts in decision making.
 - c) Documentation in the medical record.
 - d) Requirements are described in facility policy RI-15, Advance Directives Withholding or Withdrawing Life-Sustaining Treatment, Medical Staff Bylaws, and these Rules.
- 2) Moderate Sedation involves the administration of medications that may be utilized only within the guidelines of an established protocol in the facility policy, PC-63 Moderate Sedation by Non-Anesthesia Providers, and according to approved privileges. Only those Providers with approved and current privileges may administer moderate sedation.

5. ROLE OF ATTENDING STAFF

A. Supervision of Residents and Non-Physicians

- 1) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities.
- 2) 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.
- 3) Mid-Level and certain Associate Health Providers 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, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.
- 2) Entries in the medical record made by residents or those non-physicians (e.g., PAs, APRNs, etc.) that require countersigning by supervisory or attending medical staff members are covered by appropriate Facility policy and include:
 - a) Medical history and physical examination.
 - b) Discharge Summary.
 - c) Operative Reports.
 - d) Medical orders that require co-signature.

- (1) DNR.
- (2) Withdrawing or withholding life sustaining procedures.
- (3) Certification of brain death.
- (4) Research protocols.
- (5) Investigational drug usage, ONLY permitted by named principal investigators or co-investigators previously designated in the study.

(NOTE: Because medical orders in EMR do not allow a second signature (co-signature), the attending must either write the order for (1) through (4) 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.)

- 3) Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising Provider over and above standard setting-specific documentation requirements (VHA Handbook 1400 page 6).

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

6. MEDICAL RECORDS

A. Basic Administrative Requirements:

- 1) Entries must be electronically entered where possible, which automatically dates, times, and authenticates with a method to identify the author, which may include written signatures.
- 2) It is the responsibility of the medical Provider to authenticate and, as appropriate, co-sign or authenticate notes by Mid-Level Providers.
- 3) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in related Facility policy, and is available in CPRS and VistA. Those abbreviations are not acceptable for use either handwritten or in the EMR.

- 4) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.
- 5) Release of information is required per policy and standard operating procedures for the Facility.
- 6) All medical records are confidential and the property of the Facility and shall not be removed from the premises without permission (ROI from the Patient/consultation with the privacy officer as appropriate). Medical records may be removed from the Facility's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.
- 7) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

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 (as appropriate).
- 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 Facility Policy RI-14 Informed Consent.

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

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

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

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

3) Inpatient H&P must be completed within 24 hours and 48 hours for the CLC.

4) A discharge plan from any inpatient admission, including condition on discharge.

5) Have a discharge summary signed (from any inpatient admission) available for review in CPRS within two (2) business days of discharge from the inpatient setting and three (3) business days for CLC residents. For viewing in CPRS prior to discharge, or within 24 hours of a death or irregular discharge for inpatients and with 72 hours for Community Living Center (CLC) patients. Be completed within 30 days of discharge.

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

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, problem, 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 Provider 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 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.
- 3) Immediate Post-Operative Documentation: A post-operative progress note must be written, or directly entered into the patient's health record, by the surgeon immediately following surgery and before the patient is transferred to the next level of care.
- a) The immediate post-operative note must include:
 - (1) Pre-operative diagnosis,
 - (2) Post-operative diagnosis,
 - (3) Technical procedures used,
 - (4) Surgeons,
 - (5) Findings,
 - (6) Specimens removed, and
 - (7) Complications.
 - b) The immediate post-operative note may include other data items, such as:
 - (1) Anesthesia,
 - (2) Blood loss,
 - (3) Drains,
 - (4) Tourniquet Time, or
 - (5) Plan.
- 4) 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 will contain:

indication for the procedure, operative findings, technical procedure used, specimens removed, post-operative diagnosis, names of the supervising Provider, primary surgeon, assistants, and the presence and/or involvement of the supervising Provider.

5) Post Anesthesia Care Unit (PACU) Documentation:

- a) PACU documentation must include the patient evaluation on admission to, and discharge from, the post-anesthesia care unit, a time-based record of vital signs and level of consciousness (either paper or electronic), all drugs administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post-procedural complications, and post-anesthesia visits.
- b) The health record must document the name of the LIP responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.
- c) For inpatients, there will be at least one documented post-anesthesia visit after leaving the post-anesthesia care unit. The note must describe the presence or absence of anesthesia-related complications.
- d) For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery, to assess any complications, including anesthetic complications, as appropriate.

7. INFECTION CONTROL

- A. Isolation is described in the Isolation Policy, IC-14.
- B. Standard Precautions are described in the Standard and Transmission-Based Precautions Policy, IC-14.
- C. Reportable Cases are described in the Reportable Diseases Policy, IC-07.

8. CONTINUING EDUCATION

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

9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

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

- A. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified. Providers are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Line 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 Occupational Health Program or a make a referral to the Employee Assistance Program (EAP).
- C. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Fargo VA HCS Director to authorize a Fitness for Duty Examination as authorized VA Handbook 5019, Part II, and applicable hospital policy. The Fitness for Duty Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The 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 Provider's fitness for duty based on such findings. If the determination is unfavorable to the Provider, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.
- D. VA and Facility policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for physicians, dentists, and other healthcare professionals.
- E. Confidentiality of the Provider seeking referral or referred for assistance will be kept, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.
- F. The hospital will sponsor periodic educational program regarding illness and impairment issues. Licensed independent Providers will be issued written information regarding illness issues at the time of initial appointment and re-appointment to the medical staff.

10. PEER REVIEW

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

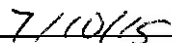
- A. All Medical Staff members will complete ongoing required training associated with the associated VHA policy.

Adopted by the Medical Staff,
Fargo VA Health Care System,
Fargo, North Dakota, this ____ Day of
July 2015.

RECOMMENDED




BRETON M. WEINTRAUB, MD, FACP
Chief of Staff

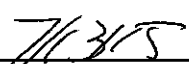


Date



APPROVED


LAVONNE LIVERSAGE, FACHE
Health Care System Director



Date