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

LEXINGTON, KY

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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 Lexington VA Medical Center (hereinafter sometimes referred to as Lexington VAMC hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs, Veterans Health Administration (VHA), and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the VHA, and they do not create any rights or liabilities not otherwise provided for in laws or VHA Regulations. The Lexington VAMC comprises all health care facilities including all inpatient and outpatient programs located at the Leestown Division, the Cooper Drive Division, and all community based outpatient clinics (CBOCs) managed by the Lexington VAMC leadership.

Portions of these bylaws are required by the VA, VHA, or The Joint Commission (TJC). These sections, designated by asterisks, should not be changed without verifying that the regulation, standard, or other requirement has changed.

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

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

3. Associate Director for Patient Care Services (AD/ PCS): The AD/ PCS is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he is the Chairperson of the Nurse Executive Counsel (NEC) and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant mid- level and certain allied health staff and in ensuring the ongoing education of the nursing staff. The AD/ PCS is a voting member at the Clinical Executive Committee at the Lexington VAMC.

4. Automatic Suspension: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Examples

are loss of licensure, or exceeding the allowed medical record delinquency rate. Privileges are automatically suspended until the license is renewed, or the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Executive Committee of the Medical Staff.

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

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

7. Contract Practioners: Contract practitioners are paid via an approved contract with the Lexington VA Medical Center. They are not considered employees of the medical center but are expected to comply with bylaws, rules and regulations, and VHA regulation. They are not voting members of the Medical Staff.

8. Director (or Facility Director): The Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the Medical Center. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS), and the Clinical Executive Council.

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

10. House Staff: The term House Staff shall refer to residents and fellows (physicians, dentists, and osteopaths) engaged in an approved course of training and education at this medical center through an affiliation agreement between the academic program

and this medical center. They are not members of the medical staff as defined in these bylaws. They are recommended for appointment for a limited period of training subject to the regulations of the VHA and the American College Graduate Medical Education (ACGME). House Staff will not have delineated clinical privileges as they do not function independently in their trainee roles. The scope of their practice is guided by the year of their post graduate experience (PGY level) and graduated levels of responsibility as documented by the program director of each training program.
Housestaff are credentialed by the University of Kentucky's Graduate Medical Education Office with concurrence of this medical center of their Resident Credentials Verification Letter prior to the house staff member's participation in patient care activities. Senior residents may be designated by their service chiefs to supervise junior residents, in accordance with graduated levels of responsibility, but any procedure performed by them shall be under the appropriate supervision of a staff member privileged to perform the procedure. House staff are expected to function in a manner which is consistent with the medical staff bylaws, rules, and regulations.
They may serve on designated medical center committees in a non-voting capacity unless specifically included as a voting member.

Some residents having full and unrestricted licenses to practice medicine, may serve as fee basis attending staff for work in the emergency room on nights, holidays, and weekends. They must schedule their work in accordance with work limitation restrictions established by their respective academic program and/or ACGME. For such work, they must be board eligible, credentialed and privileged, and meet all criteria required by VHA regulation.

Members of the house staff may also act as attending practitioners provided they are board certified in the specialty but may not hold privileges in the specialty of current training. For example, a house staff member who is board certified in Internal Medicine but is doing a fellowship in cardiology may be privileged in Internal Medicine but cannot practice independently or hold cardiology privileges. To perform as an attending practitioner under these circumstances, the individuals must be credentialed and privileged in accordance with these bylaws and VHA regulation.

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

12. Medical Staff: The body of all Licensed Independent Practitioners and other practitioners credentialed and privileged through the medical staff process that are subject to the medical staff bylaws. The medical staff includes both members of the organized medical staff and non-members of the organized medical staff who provide health care services. Medical Staff membership at the Lexington VAMC includes physicians, osteopaths, dentists, psychologists, optometrists, podiatrists, CRNAs,

ARNPs, speech pathologists, and audiologists. All VA-privileged physicians, osteopaths, and dentists members who are serving in the capacity of attending at this VA Medical Center (regardless of the method of payment), will retain responsibility within his/her areas of professional competence for the daily care and supervision of each patient in the medical center for whom he/she is providing service, or will arrange suitable alternative for such care and supervision by another member of this VA Medical Center's medical staff.

13. Mid-Level Practitioner: Mid-Level Practitioners are those health care professionals who are not physicians and dentists and include professions such as registered nurse practitioners (NPs), physician assistants (PAs), doctorate level pharmacists (Pharm.D), and certified nurse anesthetists (CRNAs). Mid-Level Practitioners may function independently via privileges if permitted by their licensure and these bylaws or may function under a scope of practice if independent practice is not permitted. Mid-Level Practitioners 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 Practitioner when required. Mid- Level Practitioners 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.

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

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

16. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges (See VHA Handbook1100.19).

17. Executive Committee of the Medical Staff: The Executive Committee of the Medical Staff (ECMS) is established to act on credentialing and clinical privileging matters of the Medical Staff. This committee also may act on matters involving Allied Health and Mid-Level Practitioners such as granting prescriptive authority, scope of practice, and

appointment. Some boards (e.g. Nursing, etc) are responsible for advancement and other issues related to their respective professions.

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

19. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider

20. 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.

21. VHA Regulations: The term VHA Regulations means the regulations set by the VHA Central Office and made applicable to its health care facilities in compliance with Federal laws.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, Lexington, VA Medical Center.

ARTICLE II. PURPOSE

The purposes of the Medical Staff shall be to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 3.01 Eligibility for Membership on the Medical Staff

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, dentists, osteopaths, optometrists, podiatrists, psychologists, audiologists, speech pathologists, nurse practitioners, and nurse anesthetists who continuously meet the qualifications, standards, and requirements of VHA, this Facility, and these Bylaws.

2. Categories of the Medical Staff:

(1) Active Medical Staff: Members assigned to the active category must be appointees of the medical staff and have a part-time or full-time paid appointment at the Lexington VA Medical Center. Appointees to the active category may:

- Exercise such clinical privileges as are granted by the board
- Vote on all matters presented by the medical staff and by the appropriate service and committee(s) to which the appointee is assigned
- Hold office and sit on or be the chairperson of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

Responsibilities of active medical staff members include:

- Contributing to the organizational and administrative affairs of the medical staff
- Actively participating as requested or required in activities and functions of the medical staff, including quality/ performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities, and the discharge of other staff functions as may be required
- Fulfilling any meeting attendance requirements as established by these bylaws or action of the Clinical Executive Council or Executive Committee of the Medical Staff
- Fulfilling or complying with any applicable medical center or VHA policies or procedures

(2) Associate Medical Staff: The associate medical staff members do not meet the eligibility requirements for the active medical staff category. These individuals are medical staff members who have fee, consultant, contract, or without compensation (WOC) appointments.

Appointees to the associate category may:

- Exercise such clinical privileges as are granted at the medical center
- Attend medical staff meetings and service meetings to which they are appointed. Members of the associate category may not vote or hold supervisory positions.

Responsibilities of associate medical staff members include:

- Contributing to the organizational and administrative affairs of the medical staff
- Actively participating as requested or required in activities and functions of the medical staff including quality/ performance improvement and peer review, credentialing, risk and utilization management, medical records completion, monitoring activities, and the discharge of other staff functions as may be required.
- Fulfilling or complying with any applicable medical staff or VHA policies or procedures

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

4. All medical staff members, regardless of voting status, are responsible for abiding by VHA regulations as well as requirements of other accrediting bodies such as The Joint Commission, etc. This includes timely completion of mandatory training and participation in quality assurance activities.

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 1 must submit evidence of:

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

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

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

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

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

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

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

h. English language proficiency.

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

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

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

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

i) Physicians

ii) Dentists

iii) Osteopaths

iv) Optometrists

v) Podiatrists

vi) Psychologists

vii) Audiologists

viii) Speech Pathologists

ix) Nurse Practitioners

x) Nurse Anesthetists

b. The following practitioners will be credentialed through Human Resource Management. The Medical Staff may elect that these practitioners be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:

i) Advanced Practice Nurses

ii) Clinical Social Workers

iii) Doctors of Pharmacy

iv) Clinical Pharmacists

C. The following practitioners will be credentialed by the Medical Staff Office every two years and will practice under a Scope of Practice with appropriate supervision (as defined by their state licensure):

i) Physician Assistants.

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

Section 3.03 Code of Conduct

1. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, *- and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being at work every day as scheduled unless on approved leave or excused absence, (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, (6) with certain exceptions, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

2. Disruptive Behavior and Inappropriate Behavior: Conduct that intimidates others to the extent that quality and safety could be compromised. These behaviors, as determined by

the organization, may be verbal or non-verbal, may involve the use of rude language, may be threatening, or may involve physical contact.

Professional Misconduct: Behavior by a professional that implies an intentional compromise of ethical standards

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. *<This mechanism can be utilized to manage conflict between the Executive Committee and the Organized Medical Staff on issues including, but not limited to proposals to adopt a rule or regulation or policy or amendment thereto.*
Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Governing Body (Director) on a rule, regulation or policy adopted by the Organized Medical Staff or the Executive Committee. The Governing Body (Director) must determine the method of this communication> VHA expects VA medical center leadership to make use of these and other resources in communicating expectations to clinicians and other staff that conflictive, disruptive, inappropriate, intimidating, and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff that 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. *<The Facility may wish to review the information found on the Office of Diversity and Inclusion (EEO) website at http://www.diversity.hr.va.gov/index.asp and these resources: Alternative Dispute Resolution: Memorandum on Alternative Dispute Resolution for Workplace Disputes, (February 8, 2007), VA Directive 5978, Alternative Dispute Resolution (February 23, 2000)*, and *VA Handbook 5978.1, Alternative Dispute Resolution Program: Central Office (December 11, 2007)>*

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. Composition:

a. Chief of Staff.

2. Qualifications: The Chief of Staff must be a board certified physician.

3. Selection: The Chief of Staff will be recommended by a Search Committee which will include at least one medical staff representative from the Lexington VAMC, one current Chief of Staff from another VA Medical Center, and representative from the University of Kentucky College of Medicine. The Medical Center Director has selection authority with final concurrence through VISN 9 and/or VA Central Office as required.

4.Duties:

a. Chief of Staff serves as Chairperson of the Clinical Executive Council.

b. The Chief of Staff is fully responsible to the Medical Center Director for programs of patient care and for the educational and research activities of the clinical services. To carry out these responsibilities, the Chief of Staff:

(1) Formulates and recommends plans for a comprehensive program of medical care.

(2) Develops the requirements of staff, facilities, equipment and supplies needed to carry forward such an integrated program, utilizing necessary reviews and controls.

(3) Appraises the effectiveness of the various medical programs in meeting the needs of patient care.

c. The Chief of Staff acts as ex-officio member of the Academic Partnership Council and is the professional liaison of the Medical Center with this committee and consultant groups. To carry out these broad professional programs, the Chief of Staff, with assistance from the clinical staff, assures that accepted management practices throughout the clinical services are maintained. The Chief of Staff assists in the formulation of the annual budget program.

d. The Medical Staff, through its committees, services and service chiefs, provides counsel and assistance to the Chief of Staff and facility Director regarding all facets of the patient care services program, including continuous quality improvement, goals and plans, mission, and services offered.

e. All Medical Staff members are eligible for consideration for membership on the Clinical Executive Board.

Section 4.02 Leadership

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

Section 4.03 Clinical Services

1. Characteristics:

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

2. Functions:

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

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

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

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

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

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

g. Annually review privilege list templates for each Service and make recommendations to Clinical Executive Council.

3. Selection and Appointment of Service Chiefs: Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff. Separate from these Bylaws, the organization determines how the 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 of each applicant. Criteria for appointment as Service Chief include Board Certification/or equivalent experience and comparable training.

4. Duties and Responsibilities of Service Chiefs: The Service Chief is administratively responsible for the operation of the Service and its clinical and research efforts as appropriate. The Service Chief is compensated under the physician's special pay program. In addition to duties listed below, the Service Chief is responsible for assuring the Service performs according to applicable VHA performance standards. These are the performance requirements applicable to the Service from the national performance contract, and cascade

from the overarching requirements delegated to the Chief of the Medical Staff. These requirements are described in individual Performance Plans for each Service Chief. Service Chiefs are responsible and accountable for:

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

b. Clinically related activities of the Service.

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

d. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges.

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

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

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

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

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

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

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

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

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

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

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

p. Recommendations for space and other resources needed by the service.

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

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.

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

3. The presence of fifty-one percent of a committee's members will constitute a quorum.

4. The members of all standing committees, other than the Clinical Executive Council (CEC), are appointed by the Chief of Staff subject to approval by the Clinical Executive Council, 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.

Section 5.02 Executive Committee of the Medical Staff

1. Characteristics: The Clinical Executive Council serves as the Executive Committee of the Medical Staff. The members of the Clinical Executive Council are:

a. Chief of Staff, Chairperson, voting.
b. Clinical Service Chiefs, including Associate Chiefs of Staffs, voting
c. Chief, Pharmacy Service, voting
d. Associate Director for Patient Care Services, voting
e. Medical Center Director, or designee, non-voting
f. Member at large, as voted upon annually by CEC members, voting
g. 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.

2. Functions of the Clinical Executive Council

The Clinical Executive Council:

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

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

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

d. Makes recommendations directly to the Governing Body regarding the:

i) Organization, membership, structure, and function of the Medical Staff.
ii) Process used to review credentials and delineate privileges for the medical staff.
iii) Delineation of privileges for each practitioner credentialed.

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

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

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

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

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

k. 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.

l. Acts upon recommendations from the Professional Standards Board.

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

n. Annually reviews and makes recommendations for approval of the Service-specific privilege lists

3. Meetings:

a. Regular Meetings: Regular meetings of the Clinical Executive Council shall be held at least quarterly. The date and time of the meetings shall be established by the Chairman 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 Clinical Executive Council 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 Clinical Executive Council.

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

c. Meeting Notice: All Clinical Executive Council members shall be provided at least one week 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 Clinical Executive Council. The Chairman shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.

e. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the Clinical Executive Council shall be a minimum of fifty one percent 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.

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

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

Section 5.03 Committees of the Medical Staff

1. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Mid-Level and Allied Health Practitioners (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual practitioners and (g) for such additional purposes as may be set forth in the charges to each committee:

a. Executive Committee of the Medical Staff – Bi-Weekly

b. Pharmacy and Therapeutics Committee - Monthly

c. Medical Records Committee - Monthly

d. Peer Review - Monthly

e. Surgical Executive Committee - Monthly

f. Mental Health Committee - Monthly

g. Cancer Committee - Quarterly

h. Chronic Pain - Monthly

i. Transfusion Review - Quarterly

j. Reusable Medical Equipment Committee - Monthly

k. Critical Care Committee - Monthly

l. Invasive Procedures Committee - Monthly

2. The charters which include membership, scope, and required reporting/ monitors must be approved by the director as per medical center memoranda are published on the Lexington VA Medical Center's intranet site. Any change in charter must be brought through the CEC for final concurrence and recommendation to the medical center director.

3. Information Flow to the Clinical Executive Committee including but not limited to those listed above, will submit minutes of all meetings to the Clinical Executive Council within week prior to Clinical Executive Committee meeting after the minutes are approved and will submit such other reports and documents as required and/or requested by the Clinical Executive Council.

4. Critical clinical issues that are discovered by members of a committee or reported to that committee shall be reported within no more than 72 hours of discovery or discussion to the Chief of Staff.

Section 5.04 Committee Records and Minutes

1. Committees prepare and maintain reports to include data, conclusions, recommendations, actions taken, and evaluation of results of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on a quarterly basis.

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

3. Each committee shall review and forward to the Clinical Executive Council a synopsis of any subcommittee and/or workgroup findings within the week prior CEC meeting to be placed on the agenda.

Section 5.05 Establishment of Committees

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

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

ARTICLE VI. MEDICAL STAFF MEETINGS

1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least annually. A record attendance shall be kept.

2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the Clinical Executive Council. 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 hours prior thereto.

3. Quorum: The Lexington VA Medical Center defines a quorum for all medical center groups in the official organizational-wide committee structure as fifty-one percent of the voting membership.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. Independent Entity: The Lexington VA Medical Center is an independent entity, granting privileges to the medical staff through the Clinical Executive Council and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Reappointments for medical staff members may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff must practice under their privileges or scope of practice. Physician Assistants are not medical staff members and are not privileged, however, are credentialed in accordance with these Bylaws. Reappointment for physician assistants may not exceed 2 years, minus one day from the date of last appointment or reappointment date.

2. Credentials Review: All Licensed Independent Practitioners (LIP) who hold clinical privileges will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. Physician Assistants are also subject to the same credentials review process. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a maximum period of 2 years. **NOTE:** *If the practitioner is a contractor, fee basis provider, or providing care under Sharing Agreement, privileges can only be granted for the length of the contract, fee basis, or Sharing Agreement not to exceed 2 years (Reference 1100.19). For example if the contract is for 1 year then the granting of privileges can only be for one* year.

3. Deployment/Activation Status:

a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be placed in a "Deployment/Activation Status" and the credentialing file will remain active. Upon return of the practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the practitioner will update the credentialing file to current status.

b. After verification of the updated information is documented, the information will be referred to the practitioner's Service Chief then forwarded to the Clinical Executive Council for recommendation to restore privileges to active, current status. The Director has final approval for restoring privileges to active and current status.

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

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

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

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

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

5. Initial Focused Professional Practice Evaluation:

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

i) Criteria for conducting performance monitoring

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

iii) Method for determining the duration of the performance monitoring

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

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

i) Initial and certain other appointments made under 38 U.S.C. 7401(1), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VHA policies and procedures.

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

Section 7.02 Application Procedures

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete application, utilizing VetPro. (VetPro is the federal internet-based credentialing program required for use by all VA facilities.) To be complete, applications for appointment must include authorization for release of information pertinent to the applicant and information as outlined below.

NOTE: *Medical Staff appointment does not equate to HR employment/ appointment. All full-time, part-time, fee, consultant, and WOC staff must complete all HR requirements in addition to requirements for credentialing and privileging as outlined in this document.*

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

i) Active, Current, Full, and Unrestricted License: Inquiry must ask for multiple licenses and process must be followed for each license (38USC 7402 (f). Qualification requirements of 3 U.S.C. Section 7402(f) state that applicants and individuals appointed on or after

November 30, 1999, who have been licensed, registered, or certified (as applicable to such position) in more than one State, and are being credentialed for a position identified in 38
U.S.C. Section 7402(b) (other than a Director) are subject to dismissal if license is revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntary relinquishment of a license, registration, or certification in any of those States, after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care. These individuals are not eligible for appointment, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status (1100.19 page 11). Limitations defined by state licensing authorities must also be considered when considering whether licensure requirements are met.

ii) Education.

iii) Relevant training and/or experience.

iv) Current professional competence and conduct.

v) Physical and Mental health status.

vi) English language proficiency.

vii) Professional liability insurance (contractors only).

viii) Certification of BLS or ACLS certification from an approved program using criteria by the American Heart Association or designated approved DoD agent, if required by
Lexington VA Medical Center policy. The requirement is based upon the applicant's specialty and privileges requested.

ix) To qualify for moderate sedation and airway management privileges, the practitioner will have specific, approved clinical privileges and must complete requirements for moderate sedation privileges as outlined in Lexington VA Medical Center policy.

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

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

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

i) Name of health care institution or practice.

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

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

e. DEA Registration: A description of:

i) Status, either current or inactive.

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

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

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

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

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

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

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

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

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

c. Verification of status of all licenses ever held by the applicant, both current and inactive.

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 submission of query to National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank, for all members of the Medical Staff and those practitioners with clinical privileges.

h. Screening with the FSMB through VetPro and, if the screen results in a disciplinary alert, primary source information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the practitioner.

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

J. Evidence and verification of the status of any alleged or confirmed malpractice. **NOTE:** *It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the practitioner, requesting the State licensing board to disclose all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint. Questions concerning applicants who may qualify for appointment under the Rehabilitation Act of 1974 need to be* referred *to Regional Counsel (VHA Handbook 1100.19).*

k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made as noted by the "Sign and Submit" screen in VetPro (VHA Handbook 1100.19).

I. The applicant's attestation to the accuracy and completeness of the information submitted as noted by the "Sign and Submit" screen in VetPro (VHA Handbook 1100.19).

3. 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 in within 30 days of the request to the applicant may serve as a basis for denial of employment consideration.

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

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

3. Executive Committee of the Medical Staff Recommendation: The Executive Committee of the Medical Staff recommends medical staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

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

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. In the case that appointment is not approved by either the Clinical Executive Council and/or the Director, reasons will be provided.

Section 7.04 Credentials Evaluation and Maintenance

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

competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.

2. **Good Faith Effort to Verify Credentials:** A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason. 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 Credentialing and Privileging (C&P) file folder and complete electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C&P folder 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) may be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a "for-cause" event requiring a focused review.

a. A FPPE implemented at time of initial appointment will be based on the practitioner's previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, or previous competence validation. The Service Chief will appoint an evaluator and will meet with the practitioner to explain what will be reviewed during the FPPE prior to the granting of privileges.

b. A FPPE at the time of request for additional privileges will be for a period to be set by the Service Chief, due to the scheduling of services. The Service Chief will appoint an evaluator and will meet with the practitioner to explain what will be reviewed during the FPPE.

c. A FPPE initiated by a "for-cause" event will be for a period to be set by the Service Chief. The Service Chief will appoint an evaluator and will meet with the practitioner to explain what will be reviewed during the FPPE. FPPE for cause requires supervision.

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

i) Criteria for conducting the FPPE.

ii) Method for monitoring for specifics of requested privilege.

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

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

e. Information resulting from the FPPE process will be integrated into the service specific performance improvement program, consistent with the Service's policies and procedures.

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

i) Extension of FPPE review period

ii) Modification of FPPE criteria

iii) Privileges (initial or additional) may not be maintained

iv) Termination of existing privileges

Section 7.05 Local and VISN-Level Compensation Panels

Local and VISN-level Compensation Panels must utilize the appropriate table, tier level and market pay amount for individual medical staff members, Appointment actions recommended by the Professional Standards Board require a separate review for a pay recommendation, if appropriate, by the appropriate Compensation Panel.

ARTICLE VIII. CLINICAL PRIVILEGES

Section 8.01 General Provisions

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

2. Reappraisal of privileges is required of each Medical Staff member and any other practitioner who has clinical privileges. Reappraisal is initiated by the practitioner's Service Chief at the time of a request by the practitioner for new privileges or renewal of current clinical privileges.

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

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

c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to

the timeliness of the verification and use for the credentialing and privileging process (1100.19 page 3). If the delay between the candidate's application and appointment, reappointment or reporting. for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Executive Committee of the Medical Staff. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7).

3. A practitioner may request modification or enhancement of existing clinical privileges by submitting formal request for the desired change(s) with full documentation to support the change to the Service Chief

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

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

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

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

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

1. 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. Practitioners must be appointed, credentialed, and privileged at the facility which receives the telemedicine services (patient site), as well as at the site providing the services. Before a practitioner conducts telemedicine, the facility where the patient is physically located must enroll the practitioner in the NPDB-HIPDB PDS. The NPDB-HIPDB PDS registration must be renewed in accordance with VHA Handbook 1100.19, Credentialing and Privileging. If this is not done, it must be clearly documented why an NPDB-HIPDB query was not completed before the practitioner engages in patient care using telemedicine. Physicians credentialed and privileged as part of the Medical Staff and Allied Health and Mid-Level Practitioners operating under a Scope of Practice of the Facility are deemed qualified to provide

Telemedicine to all components of the Facility and its patient service area (e.g., OPCs and CBOCs).

2. Teleconsultation: A practitioner providing only teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located when providing teleconsultation services. The practitioner's credentials must be shared with the facility receiving the teleconsultation services using shared access of the VetPro file. A practitioner providing only teleconsultation services does not have to be separately appointed or credentialed at the facility or site where the patient is physically located however, before a practitioner conducts telemedicine, the facility where the patient is physically located must enroll the practitioner in the NPDB-HIPDB PDS. The NPDB-HIPDB PDS registration must be renewed in accordance with VHA Handbook 1100.19, Credentialing and Privileging. If this is not done, it must be clearly documented why an NPDBHIPDB query was not completed before the practitioner engages in patient care using telemedicine

Section 8.02 Process and Requirements for Requesting Clinical Privileges

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

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

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

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

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

c. Evidence of professional training and experience.

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

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

f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency with any other professional health care organization; (2) voluntary or involuntary

relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

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

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

i. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association or designated approved DoD agency.

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

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

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

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

a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, o deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.

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

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

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

e. A statement of the current status of all licenses and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.

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

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

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

2. Verification: Before granting subsequent 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 former licenses in all states.

b. Current and former DEA registration.

c. NPDB-HIPDB query.

d. FSMB query

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

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

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

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges

1. A practitioner's request for modification or enhancement of, or addition to, existing clinical privileges is initiated by the practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Chief.

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

3. NPDB-HIPDB query will be made prior to rendering a decision.

4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Clinical Executive Council followed by the Director's approval.

Section 8.05 Recommendations and Approval for Renewal and Revision of Clinical Privileges

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

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

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

i) Medical/Clinical knowledge (education competency).
ii) Interpersonal and Communication skills (documentation; patient satisfaction).
iii) Professionalism (personal qualities).
iv) Patient Care (clinical competency).
v) Practice-based Learning & Improvement (research and development).
vi) System-based Practice (access to care).

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

3. The Executive Committee of the Medical Staff, or the committee responsible for the Medical Executive Function, recommends granting clinical privileges to the Facility Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. A subcommittee of Executive Committee of the Medical Staff that serves as executive committee of the medical staff can make the initial review and recommendation but this information must be reviewed and approved by the

Executive Committee of the Medical Staff. Clinical privileges are acted upon by the Director within 14 calendar days of receipt of the Executive Committee of the Medical Staff's recommendation to appoint. The Director's action must be verified with an original signature.

4. Originals of approved clinical privileges are placed in the individual practitioner's Credentialing and Privileging Folder. Copies of approved privileges are distributed to the practitioner and are readily available to appropriate staff for comparison with practitioner procedural and prescribing practices.

5. Approval of the scope of practice and prescriptive authority for Mid-Level and Allied Health Practitioners, as previously defined, will be reviewed by the Executive Committee of the Medical Staff or designated subcommittee, approved by the Chief of Staff and will be reported to the Clinical Executive Council.

Section 8.06 Exceptions

1. Temporary Privileges for Emergent Patient Care Needs: Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of a temporary appointment for a limited period of time (not to exceed 60 calendar days) by the Director or Acting Director on the recommendation the Chief of Staff. Temporary privileges will only be considered in the most urgent of patient care circumstances and will not be used for administrative convenience or to recover from poor planning or scheduling.

a. Temporary privileges are based on verification of the following:
i) One, active, current, unrestricted license with no previous or pending actions.
ii) One reference from a peer who is knowledgeable of and confirms the practitioner's competence and who has reason to know the individual's professional qualifications.
iii) Current comparable clinical privileges at another institution.
iv) Response from NPDB-HIPDB PDS registration with no match.
v) Response from FSMB with no reports.
vi) No current or previously successful challenges to licensure.
vii) No history of involuntary termination of medical staff membership at another organization.
viii) No voluntary limitation, reduction, denial, or loss of clinical privileges.
ix) No final judgment adverse to the applicant in a professional liability action.
b. A completed application must be submitted within three days of temporary privileges being granted.

2. Expedited Process: The expedited process will also only be considered for emergent or urgent patient care needs. Expedited privileging will only be considered for urgent patient care situations and will not be utilized for administrative convenience or to recover from poor planning and scheduling.

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

b. The Facility:

i) Verifies education and training;

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

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

iv) Queries licensure history through the FSMB Action Data Center and receives a response with no report documented;

v) 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) institution(s) where the applicant holds or held privileges, or who would have reason to know the individual's professional qualifications.

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

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

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

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

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

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

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

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

e. Full credentialing must be completed within 60-workdays of the date of the Director's signature and presented to the Executive Committee for the Medical Staff 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. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.

4. Disaster Privileges: In the event of the implementation of the organization-wide disaster management plan, Disaster Privileges may be approved by the medical center director, or his/her designee, if it is determined that it is not possible to handle the influx of patients with the existing Practitioners. Any of the following will be accepted as credentials verification process for emergency volunteers to provide patient care in the facility:

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

- And one of the following:
- A current medical facility photo ID card.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
- Identification that the individual has been granted authority to render patient care in emergency circumstances by a Federal, state, or municipal entity.

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

In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the 10 calendar days or the length of the declared disaster, whichever is shorter, noted in paragraph b above, the Practitioner 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.

An assigned, appropriately credentialed and privileged physician oversees the professional practice of each volunteer, Licensed Independent Practitioner, Mid-Level Practitioner, and Allied Health Practitioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

i. Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.
ii. Registration with the NPDB-HIPDB PDS with no match.
iii. A response from the FSMB with no match.
iv. Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.
v. Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

Section 8.07 Medical Assessment:

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 complete and focused history and physical examination is delineated in Section 3: Responsibility For Care, of the Medical Staff Rules and Regulations.

ARTICLE IX INVESTIGATION AND ACTION *

1. Request for Investigation: Whenever the behaviors, activities and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Facility Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct, which constitute the grounds for the request. The Chief of Staff promptly notifies the Director in writing of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. NOTE: If the person under review is an employee then the processes must also follow VA Directive 5021 - Management of Employees (Appendix A pages 2-9).

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

standards of the Medical Staff or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the Executive Committee of the Medical Staff.

3. Review by the Professional Standards Board (PSB): The Professional Standards Board (PSB) may be called to investigate the charges and makes a report of the investigation to the Executive Committee of the Medical Staff within 14 days after the PSB has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the PSB for 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 PSB 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 Executive Committee of the Medical Staff.

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

iv) Failure to maintain the mandatory requirements for membership to the medical staff.

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

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

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

6. Union Representation: When the Practitioner is a union member, he/she has the right to representation in the interview processes described in paragraphs 1 through 6 of this Article IX.

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

   a. The appointment of an ad hoc investigation committee;

   b. The conduct of an investigation into any matter;

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

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

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

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

   g. Corrective counseling;

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

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

ARTICLE X FAIR HEARING AND APPELLATE REVIEW *

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

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

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

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

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

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

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

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

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

i. Be present throughout the evidentiary proceedings.

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

iii. Cross-examine witnesses.

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

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

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

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

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

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

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

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

shall do the following:

- Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
- Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.
- Maintain decorum throughout the hearing.
- Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
- Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.
- Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.
- Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

Practitioner Rights:

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

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

- The Director will issue a written decision within l0 workdays of the day of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.

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

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

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

- The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.

- If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, if greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

5. Revocation of Privileges:

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

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

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

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

6. Reporting to the National Practitioner Data Bank2:

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

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

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

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

- VA only reports adverse privileging actions that adversely affect the clinical privileges of Physician and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4 The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or

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[2] Reference VHA Handbook 1100.17.

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.

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

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

ARTICLE XI RULES AND REGULATIONS *

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

ARTICLE XII AMENDMENTS *

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

2. The 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 electronically. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.04 should be followed.

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

4. Changes are effective when approved by the Director.

ARTICLE XIII ADOPTION *

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

If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy or an amendment thereto, they must first communicate the proposal to the Executive Committee. If the Executive Committee proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the medical staff. When the Executive Committee adopts a policy or amendment thereto, it must communicate this to the medical staff. *<This applies only when the organized medical staff, with the approval of the Director, has delegated authority over such rules, regulations, or policies to the Executive Committee>*

RECOMMENDED

//ss//

Joseph A. Pellecchia, MD, FACP Chief of Staff

Date

APPROVED

//ss//

Emma Metcalf RN, MSN, CPHQ

Interim Director

Date

MEDICAL STAFF RULES

1. GENERAL

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

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

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

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

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

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

2. PATIENT RIGHTS*/ STAFF RIGHTS

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

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

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

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

iv) Pain management including assessment, treatment and education.

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

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

vii) Access to information necessary to make care decisions that reflect patient's wishes, including potential outcomes, risks and benefits and consequences of refusal of treatment.

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

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

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

xi) Personal privacy and confidentiality of information.

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

xiii) Authority of <Insert appropriately identified individual, i.e. Chief of Staff or Service Chief> to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available).

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

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

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

xvii) 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.

xviii) 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).

xix) 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.

xx) 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.

xxi) 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.

xxii) 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.

B. Staff Rights:

A. Staff have the right to request that they not be a participant in a patient's care based on cultural values, ethics, or religious beliefs. Any request by an employee to not participate in an aspect of a patient's care, including treatment because of cultural values, ethics, or religious beliefs, will be addressed. If a request to not participate in a patient's care is granted, that patient's care (including treatment) will not be negatively affected. The provider making the request must continue providing patient care until his or her request is approved.

B. Patient care issues that may lead to conflicts include, but are not limited to, withholding care, discontinuance of active care for the terminally ill patient, initiating or continuing treatment on the incompetent, resistive, and/or terminally ill patient, organ donation, and/or blood transfusions.

C. Employees who perceived a religious, ethical, or value conflict regarding an aspect of care for a specific patient, will notify their supervisor of the conflict as soon as a conflict is recognized. The immediate notification may be verbal; however a written request must follow by the end of the tour of duty, if the employee desires to not participate in the patient's care. (The supervisor can grant an extension of this time limit.) The written request must include specific details of the nature and basis of the conflict with sufficient detail to allow an informed discussion and decision by the supervisor and others.

3. RESPONSIBILITY FOR CARE*

A. Conduct of Care

i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff. The medical staff member is also responsible for prompt completeness and accuracy of the medical record. When acting in the capacity as supervisor of practitioners in training, the medical staff member shall be responsible for assuring that those delegated to care for the patient are doing so in an adequate and timely manner. Evidence of supervision shall be the signature of the staff physician/oral surgeon in the medical record.

(a) 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, updated problem list, identification data, chief complaints, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathological findings, progress notes, doctor's

discharge instructions sheet, including condition on discharge (discharge note) and final diagnosis, and final summary.

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

Medical Assessment of the patient 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

(c) The staff physician responsible for the patient must sign the admission note if it is prepared by a resident, fellow, or Mid-Level Practitioner, or make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" or make whatever comments he/she thinks the case warrants, or prepare a complete admission within forty eight (48) hours of admission to the CLC. In the event a resident, intern, or Mid-Level Practitioner prepares an admission workup, all 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.

(d) 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.

(e) 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.

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

(g) Evidence of required supervision of all care by the attending physician shall be documented in the medical record, the frequency of notes dependent upon the severity of the illness of the patient. It is a cardinal principle that responsibility for the care of each patient lies with the staff physician to whom the patient is assigned and who supervises all care rendered by residents.

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

(i) 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. <NOTE: Please refer to the following resource when considering changes to this section: Inter- Facility Transfer Policy - VHA Directive 2007-015, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1561>

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

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

B. Consultations:

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

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

(b) The diagnosis is obscure, and/or

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

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

iii) Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

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

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

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

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

ii) Discharge planning is documented in the medical record.

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

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

D. Discharge

i) Patients shall be discharged from the Facility only upon the written order of the physician and the discharge summary will be completed no later than the day of discharge. All discharge summaries will be completed in compliance with current VA guidance. 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 seven (7) days of the discharge of the patient. The physician or dentist shall complete his/her portion of the record within seven (7) days, including authentication.

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

E. Autopsy

i) Autopsy services are provided through the Pathology Service of the Lexington VA Medical Center. 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.

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

iii) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.155 and JAHVH HPM 11- 31 Autopsy Services (which includes Criteria for assignment to medico-legal status).

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

v) Autopsy Criteria. VHA policy encourages autopsies be requested from next-of- kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in JAHVH HPM 11-31, Autopsy 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.

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

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

4. PHYSICIANS' ORDERS *

A. General Requirements

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

ii) Verbal orders are strongly discouraged except in emergency situations.

iii) Telephone orders will be accepted when the provider is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS. They will be accepted by Registered Nurses, Pharmacists, Physician Assistants, Advanced Practice 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 signed electronically by the physician within 24-hours or the next working day whichever is earlier.

B. Medication Orders

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

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

iii) 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 14 days or less.

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

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

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

iv) Ambulatory Care Medication Orders:

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

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

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

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

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

C. Standardized Order Sets (protocols): Standardized order sets are reviewed periodically by Section or Service Chief and modified as needed. All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff

member and are to be signed for each usage by medical staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief.

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

E. Informed Consent:

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

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

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

G. Special Treatment Procedures:

i) DNR (Do Not Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment <Note: Assure compliance with all appropriate VHA policy>

(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 Memoranda, Medical Staff Bylaws, and these Rules.

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

5. ROLE OF ATTENDING STAFF *

A. Supervision of Residents and Non-Physicians: Resident supervision must be in accordance to VHA regulations (VHA Handbook 1400.1). In summary:

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

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

iii) Mid-Level and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

B. Documentation of Supervision of Resident Physicians

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

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

(a) Medical history and physical examination.

(b) Discharge Summary.

(c) Operative Reports.

(d) Medical orders that require co-signature.

(1) DNR.

(2) Withdrawing or withholding life sustaining procedures.

(3) Certification of brain death.

(4) Research protocols.

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

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

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

C. Administrative staff may be authorized to make administrative entries as approved by the Chief of Staff. These administrative entries can be for the purposes of: (1)

creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering notes to disposition consultation requests and (5) completing other requirements as requested by the Chief of Staff or his/her designee.

6. MEDICAL RECORDS *

A. Basic Administrative Requirements:

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

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

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

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

v) Release of information is required per policy and standard operating procedures for the Facility and VHA regulation.

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

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

B. All Medical Records must contain:

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

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

iii) Observations, including results of therapy.

iv) Diagnostic and therapeutic orders.

v) Reports of procedures, tests and their results.

vi) Progress notes.

vii) Consultation reports.

viii) Diagnostic impressions.

ix) Conclusions at termination of evaluation/treatment.

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

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

i) Content of H&P Examination:

(1) The H&P must contain sufficient information to support the diagnosis or differential diagnosis, justify the treatment plan, and facilitate the care after discharge.

(2) Patients requiring an H&P will receive a documented H&P, or a focused (short) H&P, or an interval note as required.

(3) H&P is defined as one that contains the following elements:

(a) History

1) Chief Complaint
2) History of present illness
3) Medications
4) Allergies
5) Pertinent past medical and surgical history
6) Review of Systems relevant to the situation

(b) Physical
1) Exam of body system responsible for the admission or procedure
2) Exam of any other body system(s) related to the specific situation

(c) Diagnosis

(d) Planned Course of treatment

(4) A focused (short) H&P may be utilized by Medicine, Mental Health, Surgery Services, Observation and Neurology when the note contains required elements as outlined below:

(a) Medicine – In general, all patients admitted to Medicine, other than Observation, require an H&P. Exceptions are individuals readmitted for the same or similar problems within 30 days of an earlier admission. In that case, requirements may be met by a complete physical and an interval history, referring back to the earlier H&P, and noting change, if any.

(b) Mental Health – For admission through the Emergency Department (ED), the evaluation by the ED physician can count as the H&P for admission purposes IF there is a focused psychiatric exam/history in the Mental Health note within 24 hours.

For elective/scheduled admission, there must be a complete H&P within the preceding 30 days and a focused psychiatric exam/history in the Mental Health note within 24 hours. Complete H&P can be from an admission to another service, an ED visit, a pre-op clinic clearance, etc. If there isn't such an H&P, the Mental Health physician is responsible for completing an H&P.

(c) Surgery -

- A Focused H&P will be used for local procedures not involving Anesthesia, and will include the following:
  (a) History
  (b) Exam relevant to the situation
  (c) Diagnosis
  (d) Planned course of treatment

- An acute/urgent admission will have the H&P documented within the electronic record as soon as practicable. In no instance will H&P documentation requirements delay emergent care required by the patient. If the patient came through the ED or was transferred after admission to another service, the H&P from the ED or the admission from the other service will meet this requirement IF there is a focused surgical exam/history within 24 hours of the procedure.

(d) Observation (any service) – Patients admitted to Observation status require only the elements of an H&P the physician performing the procedure deems necessary. In some cases, this may consist of only vital signs and documentation of procedure performance and complications if any.

For patients admitted to Observation for an overnight stay, only a focused history and physical containing those elements deemed relevant to the specific patient's circumstances is required.

Patients converting from Observation to a regular admission must meet the requirements outlined within this policy for the service to which the patient is being admitted.

(e) Nursing Home – Patients admitted to a nursing home must have a complete H&P recorded in the medical record within 48 hours of admission. If the patient's length of stay exceeds 365 days, an annual physical exam must be completed.

(f) Acute Care – If a patient's admission to acute care exceeds 365 days, an annual physical exam must be completed by the treating service of record on the day of the patients 365th day of care. This applies to all treating services.

(g) Neurology – For admission through the ED, the evaluation by the ED physician can count as the H&P for admission purposes IF there is a focused neurologic exam/history within 24 hours of admission.

(5) An interval note is a statement entered into the medical record documenting a patient's H&P has been reviewed and there are no significant interval changes. Note includes the following:

(a) An appropriate assessment was completed upon admission confirming the necessity for the procedure or care is still present; and the patient's condition has not changed since the H&P was originally completed, or any changes are documented.

ii) The note must be authenticated by provider at the earliest possible time, but always within 24 hours of being written in CPRS.

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

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

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

iv) Completed within 30 days of discharge.

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

i) A progress note for each visit.

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

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

iv) Immunization status, as appropriate.

v) Allergies.

vi) Referrals and communications to other providers.

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

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

E. Surgeries and Other Procedures:

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

ii) Preoperative Documentation:

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

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

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

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

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

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

(1) Pre-operative diagnosis,

(2) Post-operative diagnosis,

(3) Technical procedures used,

(4) Surgeons,

(5) Findings,

(6) Specimens removed, and

(7) Complications.

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

(1) Anesthesia,

(2) Blood loss,

(3) Drains,

(4) Tourniquet Time, or

(5) Plan.

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

v) Post Anesthesia Care Unit (PACU) Documentation:

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

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

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

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

F. Time standards:

a. A complete history and physical examination shall in all cases be documented within 24 hours after admission for acute patients and 48 hours for long term care patients. Earlier documented reports will be complied with, if necessary. When such history and physical examination are not recorded before the time stated for operations, except in emergencies, the operation shall be canceled unless the surgeon documents that such delay would constitute a hazard to the patient. Preprocedural evaluations in the medical record may be regarded as valid for a period of thirty days for patients with stable diseases or conditions or those who are undergoing elective procedures; however, the patient must be reassessed on the day of the procedure and the note amended accordingly. If there are no clinical changes, the note must be amended as such and resigned and dated. Preprocedural evaluations that are older than thirty days may be updated with a focused review in the progress note. If the focused review is performed on a date other than the procedure date, a reassessment must be noted on the day of procedure.

b. An admission note will be completed by the attending physician within 24 hours of admission. A note will be entered daily thereafter by the attending physician for all inpatients.

c. All operative reports will be documented or dictated immediately following surgery and the report promptly signed by the surgeon and made a part of the patient's current medical record. Failure to complete operative reports within 48 hours may be grounds for action by the Executive Committee of the Medical Staff including the suspension of all surgical clinical privileges.

d. It is expected that the medical center discharge summary will be dictated prior to the patient’s release from the medical center or immediately thereafter. The dictation should be completed by the primary physician who assumed care of the patient during the inpatient stay. Discharge summaries are to be completed no later than 30 days post discharge. Completion includes signature by the attending physician. Failure to complete the discharge summaries by medical staff members in a timely manner may lead to consideration by the Executive Committee of the Medical Staff for recommendations as to suspension or dismissal from the staff.

e. Medical center records for discharged patients will be completely processed within 30 calendar days or 20 working days following discharge. No medical record shall be filed until it is completed except on the recommendation of the Medical Records Committee and the approval of the Chief of Staff.

f. In the event that a physician is unable to complete records due to illness, death,

personal injury, etc., the responsible service chief will designate another physician familiar with the case to complete the record. The service chief will be responsible for the completion of all records that remain incomplete for over thirty days. Records may also be administratively closed with approval by the Clinical Executive Board.

g. All records are the property of the medical center and shall not be removed from the premises, except by court order, subpoena, or statute, or in accordance with the provisions for handling medical records as established by the VA. In case of readmission of a patient, all previous records on file shall be available for the use of the practitioner.

h. Autopsy: Provisional anatomic diagnoses will be completed within 3 days; complete protocol within 60 days.

G. Adverse Actions for Delinquent Medical Records - Medical staff members (non- house staff) that do not complete their patient's records in accordance with VA policy and bylaws also subject themselves to disciplinary action as well including impact to performance pay, action by the Executive Committee of the Medical Staff, and/or personnel action through Human Resource Management Service. Specific procedures related to delinquent record notification process and the suspension process for housestaff is outlined in Medical Center Memoranda.

7. INFECTION CONTROL *

A. Isolation is described in the Lexington VA Medical Center's Infection Control Manual and memorandum.

B. Standard Precautions are described the Lexington VA Medical Center's Infection Control Manual and memorandum.

C. Reportable Cases are described in the Lexington VA Medical Center's Infection Control Manual and memorandum.

8. CONTINUING EDUCATION *

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

9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM *

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

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

B. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the <insert name of appropriate facility, local, or state impaired professionals evaluation and monitoring program>.

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

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

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

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

10. PEER REVIEW *

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

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

11. Requirements for BLS and ACLS: Treatment team members required to have BLS and ACLS are outlined in VA Lexington Medical Center memorandum 11-50, "Cardiopulmonary Resuscitation". If required, maintenance of BLS and ACLS certification is the medical staff member's responsibility and is considered a condition of employment.

12. Disclosure Policy -

Disclosure Policy – VHA Directive 2008-002,
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1637;

13. Quality Management -

Quality Management Directive – VHA Directive 2008-061,
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1778;

Adopted by the Medical Staff, Lexington VA Medical Center, Lexington, KY June 2011

BYLAWS, RULES AND REGULATIONS

of the

MEDICAL STAFF

of

ROBLEY REX VETERANS AFFAIRS MEDICAL CENTER

LOUISVILLE, KENTUCKY

Revised May 27, 2015

VA MEDICAL CENTER LOUISVILLE, KENTUCKY BYLAWS,
RULES AND REGULATIONS OF THE MEDICAL STAFF

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BYLAWS, RULES AND REGULATIONS OF THE MEDICAL STAFF OF VA MEDICAL CENTER, LOUISVILLE, KENTUCKY

PREAMBLE

Recognizing that the medical staff is responsible for the quality of patient care, treatment and services delivered by its members and accountable to the governing body for all aspects of that care, the medical staff practicing at the VA Medical Center, Louisville, Kentucky, hereby organize themselves for self governance in conformity with the laws, regulations and policies governing Veterans Health Administration (VHA) and the Bylaws, Rules and Regulations hereinafter stated. These Bylaws, Rules and Regulations are consistent with all laws and regulations governing VA (Department of Veterans Affairs) and they do not create any rights or liabilities not otherwise provided for in laws or VA regulations.

As members of the Organized Medical Staff, we are charged to actively participate and exercise professional leadership in measuring, assessing and improving the performance of the organization in interactions between individual staff members and patients, clinical departments and among the overall organization. As such we are further charged to provide a uniform standard of quality patient care, treatment and services by: providing patient care within the parameters of professional competence, as reflected in the scope of delineated privileges; practicing within the framework of (implicit or explicit) clinically relevant and scientifically valid standards, guidelines, and criteria; participating in ongoing measurement, assessment, and improvement of both clinical and non-clinical processes and the resulting patient outcomes.

The Louisville VA Medical Center is a tertiary care facility providing both inpatient and outpatient care serving veterans residing in 30 counties in Kentucky and 13 counties in Indiana as well as active duty personnel at Fort Knox, KY. Patient care services are defined within the Scope of Care and are provided either directly or through contract or sharing agreements.

The Mission Statement of VA Medical Center, Louisville, Kentucky is outlined in Appendix A.

DEFINITIONS

1. **Organized Medical Staff**

The governance structure of the medical staff, including the medical staff's bylaws, rules, and regulations to which the medical staff is subject. This structure is approved by the governing body of the organization.

2. **Medical Staff**

a. The active staff consists of full-time and part-time physicians, dentists, podiatrists, optometrists, doctoral level psychologists, doctoral level audiologists, doctoral level speech pathologists, clinical pharmacy specialists, and advanced practice registered nurses employed by the medical center. Voting status is awarded to active staff only.

b. The Associate Staff consists of consultant, attending, fee for service, fee basis, contract, and without compensation physicians, dentists, podiatrists, optometrists, doctoral level psychologists, doctoral level audiologists, doctoral level speech pathologists, and advanced practice registered nurses. Associate staff does not have voting privileges.

3. **Governing Body**

In the VA system, the Medical Center Director is the Governing Body through authority delegated to him/her by the Secretary of Veterans Affairs.

4. **Medical Center Director**

The Director provides continuity, control and guidance of medical center activities to ensure patient safety and the provision of appropriate quality care for patients. The Director oversees the mission, vision and strategic planning efforts of the medical center. The Director reports to the Network Director and is assisted by the Chief of Staff (with the Clinical Executive Board) and the Associate Medical Center Directors.

5. **Chief of Staff**

The physician appointed by the Network Director, based upon recommendation of the Medical Center Director and Academic Partnership Council, whose responsibilities include oversight of the medical staff functions, quality of care and the educational and research activities of clinical departments.

6. **Academic Partnership Council**

Committee established by a formal memorandum of affiliation between the VA Medical Center, Louisville, Kentucky and the University of Louisville School of Medicine and School of Dentistry and approved by the Medical Center Director; composed of the dean and senior faculty members of the University of Louisville, representative(s) of the medical/dental staffs of the VA Medical Center; and such other faculty of the University of Louisville and staff of the medical center as are appropriate to consider and advise on development, management, planning and evaluation of all educational and research programs conducted at the medical center. Members can be nominated by the Dean of the Medical School; final appointment is approved by the Medical Center Director.

7. **House Staff**

Individuals who are not members of the medical staff but who are engaged in residency or fellowship training through affiliate University of Louisville School of Medicine or School of Dentistry and participate in patient care under the direction of a medical staff member.

8. **Allied Health Professionals**

Individuals who are not members of the medical staff but who are permitted by law and by the Organized Medical Staff to provide patient care services under the direction of the

assigned department within a functional statement and scope of practice consistent with license, education, training, experience, and competency. (e.g. Physical Therapists, Occupational Therapists, Certified Respiratory Therapists, Clinical Pharmacists)

9. **Licensed Independent Practitioner (LIP)**

Individuals who are permitted by law and by the Organized Medical Staff to provide patient care services without direction or supervision at the medical center within the scope of the individual's license and consistent with individually granted clinical privileges. References to the term "licensed independent practitioner" are not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants) to the extent authorized by state law or a state's regulatory mechanism or federal guidelines and organizational policy.

10. **Clinical Privileges**

Authorization granted by the Organized Medical Staff and the Medical Center Director to an LIP to provide specific care services within well-defined limits, based upon license, education, training, experience, competence, health status and judgment.

11. **Clinical Executive Board (CEB)**

Executive committee of the medical staff chaired by the Chief of Staff and empowered to act on behalf of the medical staff. It carries out its work within the medical staff functions of governance, leadership and performance improvement activities.

12. **Medical Center**

Refers to the Department of Veterans Affairs Medical Center located in Louisville, Kentucky and its related outpatient centers.

13. **Appointment**

As used in this document the term refers to appointment to the medical staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract or other authority for providing patient care services at the medical center.

14. **Executive Leadership Council (ELC)**

Leadership council composed of key clinical and administrative medical center staff chaired by the Medical Center Director and charged with the overall responsibility of continual outcome assessment of clinically related issues. The medical center's Boards report to ELC.

15. **Rules and Regulations**

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

16. **Telemedicine**

Refers to patient care provided through the use of electronic communication or other communication technology, characterized by a telemedicine link, to provide or support clinical care at a distance. All telemedicine services must be approved by the CEB. LIPs must have individual clinical privileges to perform such services.

17. **Peer**

Individual from the same discipline i.e. physician and physician, dentist and dentist and with essentially equal qualifications. The term "peer" is defined as an individual of similar education, training, licensure and clinical privileges.

18. **Physician, Qualified**

Doctor of medicine or osteopathy who by virtue of education, training and demonstrated competence is granted clinical privileges by the medical center to perform specific diagnostic or therapeutic procedures and who is fully licensed to practice medicine.

19. **Oral Surgeon, Qualified**

An individual who has successfully completed a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education and who is granted clinical privileges to perform a complete History & Physical (H&P) examination in order to assess the medical, surgical, and anesthetic risks of the proposed operative and/or other procedure.

20. **Physician Assistants (PA)**

An individual who practices medicine with supervision by licensed physicians, providing patients with services ranging from primary medicine to specialized surgical care. The scope of practice is determined by the supervising physician's delegation of responsibilities, the individual's education and experience and the specialty and setting in which the individual works.

21. **Healthcare Quality, Safety, and Value Executive Board**

The Healthcare Quality, Safety, and Value Executive Board has leadership and oversight responsibility on all issues of performance improvement (PI) and quality of patient care and service provided by the medical center. Primary areas of focus include continual readiness for accreditation review, organizational level PI efforts, consultation on PI issues of concern, patient safety, performance measures identified by VA policy.

22. **Administrative Executive Board**

The Administrative Executive Board (AEB) serves as an administrative advisory board to the Medical Center Director. The findings, evaluations and recommendations of the AEB provide the Medical Center Director with concise and complete information to assist him/her in making decisions concerning the operation of the medical center and consistent with the current-year operating plan and the requirements of M-1 Part 1.

23. **Compliance and Business Integrity Board**

The Compliance and Business Integrity Board (CBIB) provides guidance to local leadership on how the organization is meeting its requirements in accordance with established legal, regulatory, and ethical standards. The CBIB deals with compliance-related issues and provides guidance the Compliance and Business Integrity Officer.

24. **Veteran's Experience Board**

The Veteran's Experience Board (VEB) focuses on the commitment of the medical center to providing "world class" customer service and quality healthcare to our consumer base population. The VEB will develop and oversee the implementation of initiatives that are focused on improving service delivery systems and patient satisfaction, based on the medical center's Key Business Drivers. The VEB functions as a resource to the Medical Center Director in determining goals; and ensuring customer satisfaction as a criterion in decision-making.

25. **Organizational Health Board**

The Organizational Health Board develops and oversees the implementation of initiatives and training activities that are focused on enhancing the overall performance, morale, and work environment of the medical staff and facility staff.

26. **Integrated Ethics Board**

The Integrated Ethics Board oversees and supports implementation of the facility Integrated Ethics program. The Integrated Ethics program targets three levels of individual and organizational practices—decisions and actions, systems and processes, and environment and culture—by establishing the Ethics Consultation service, the Preventative Ethics team, and an ethical leadership function.

27. **Patient Care Executive Board**

The Patient Care Executive Board is the executive committee for patient care delivery and is empowered to act on behalf of patient care delivery. The Board carries out its work within the context of the medical staff functions of governance, leadership, and performance improvement, and participates in the continual readiness accreditation process.

ARTICLE I

NAME

The name of this organization shall be the Medical Staff of the Robley Rex VA Medical Center, Louisville, Kentucky.

ARTICLE II

PURPOSE

1. The purpose of the medical staff shall be to:

a. Ensure all patients treated at the VA Medical Center on any of the services will receive efficient, timely and appropriate care that is subject to continuous PI.

b. Ensure all patients being treated for the same health problem or with the same methods/procedures receive a uniform level of care, throughout the medical center.

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

d. Develop and adhere to facility specific mechanisms for appointment to the medical staff, and to the credentialing and delineation of clinical privileges.

e. Provide educational activities related to care provided, findings of quality of care review activities and expressed need of caregivers.

f. Ensure LIPs authorized to practice in the facility do so within their delineated clinical privileges. Ensure allied health professionals authorized to practice in the facility do so within their authorized functional statement and scope of practice.

g. Ensure a high level of professional performance of LIPs and allied health professionals authorized to practice in the facility through continuous PI practices, and the appropriate delineation of clinical privileges.

h. Adopt, amend and enforce Medical Staff Bylaws concurrent with rules and regulations for self-governance of the medical staff. Assists the Medical Center Director in developing and maintaining such rules for medical staff governance and oversight and provide a method whereby problems of a medical/administrative nature may be discussed by the medical staff and the Governing Body.

i. Bring the dimension of medical staff leadership to deliberations by the Medical Center Director as impacts patient care, policy, procedure, continuous PI, organizational management and planning.

j. Actively develop and implement continuous quality improvement activities and strategies.

k. Provide a means whereby issues concerning the medical staff and patient care may be discussed by the Organized Medical Staff with the Governing Body.

l. Create a framework within which medical LIPs and allied health professionals can act with a reasonable degree of freedom and confidence.

m. Provide a means for the effective functioning of activities related to professional graduate education.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION 1 Membership Eligibility

1. Medical staff membership is extended only to, and continued for, professionally competent physicians, dentists, podiatrists, optometrists, doctoral level psychologists, doctoral level audiologists, doctoral level speech pathologists, and advanced practice registered nurses who continuously meet the qualifications, standards and requirements of VHA, this VA Medical Center, and these Bylaws, Rules and Regulations.

2. Categories of medical staff membership include:

a. Active Staff: The active medical staff shall consist of full-time and part-time physicians, dentists, oral surgeons, podiatrists, optometrists and doctoral level psychologists, doctoral level audiologists, doctoral level speech pathologists, and advanced practice registered nurses who are professionally responsible for specific patient care, education or research activities, and who assume all the functions and responsibilities of active staff membership. The active staff has full voting privileges.

b. Associate Staff: The associate staff consists of consultant, attending, fee for service, fee basis, contract, and without compensation physicians, dentists, podiatrists, optometrists, doctoral level psychologists, doctoral level audiologists, doctoral level speech pathologists, and advanced practice registered nurses. Associate staff members do not have voting privileges.

3. All members of the medical staff are expected to:

a. Maintain professional competency;
b. Participate in PI activities/programs; and
c. Serve as committee members, when called upon to do so.

4. Decisions regarding medical staff membership are made without discrimination for such reasons as race, color, religion, national origin, sex, lawful partisan political affiliation, marital status, physical or mental handicap (when the individual is qualified to do the work),

age, or membership or non-membership in a labor organization or on the basis of any other criteria unrelated to professional qualifications.

5. Criteria are uniformly applied to all applicants for medical staff membership.

SECTION 2 Qualifications for Clinical Privileges

1. To qualify for clinical privileges, individuals who meet the eligibility requirements identified in Section 1 must submit evidence of:

a. Active, current, full and unrestricted license to practice individual's profession in a State, Territory or Commonwealth of the U.S. or the District of Columbia as required by VA employment and utilization policies and procedures.

2. Education applicable to individual medical staff members as defined, e.g., hold a degree of Doctor of Medicine, Osteopathy, Dentistry, Podiatry, Psychology, Optometry, Audiology and Speech Pathology or Master's degree, doctorate or post masters certificate related to advanced practice nursing from an approved college or university.

3. Relevant training and/or experience, consistent with the individual's professional assignment and privileges for which applying including all post graduate training. This includes any internships and residencies approved by the Council of Graduate Medical Education of the American Medical Association or the Education Commission for Foreign Medical Graduates (ECFMG), board certification or specialty training.

4. Current competence consistent with the individual's assignment and the privileges for which applying including most recent privileges held. For new appointments to the medical staff, current competence is documented by recommendations from peers and supervisors attesting to the applicant's ability to perform satisfactorily the privileges requested.

5. Health status consistent with physical and mental capability of satisfactorily performing the duties of the medical staff assignment within clinical privileges.

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

7. Satisfactory findings relative to previous professional competence, professional conduct, and ethical standards.

8. Documented participation in continuing medical education.

9. English language proficiency.

10. Ability to meet response time criteria established for the service in which they maintain clinical privileges but not to exceed 30 minutes.

11. Board certified in the clinical specialty area in which they will practice is preferred, required for Advanced Practice Nurses. Physicians who are not board certified may be appointed as outlined in VHA policy.

12. Applicant must be a citizen of the United States or may be considered for appointment with proof of current VISA status.

SECTION 3 Basic Responsibilities of Licensed Independent Practitioners (LIPs)

1. LIPs, both members of the medical staff and non-members, are accountable for and have responsibility to:

a. Maintain professional competency within their designated discipline.

b. Provide for continuous care of patients assigned to their care and to arrange for transfer of care when appropriate.

c. Observe patients' rights in all patient care activities.

d. Participate in continuing education, peer review, continuous PI activities, and medical staff monitoring and evaluation.

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

(1) Comply with Federal law and VA rules and regulations regarding ethics and financial conflict of interest, outside professional activities for remuneration and third party reimbursement.

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

(3) Advise the Medical Center Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of notification of such occurrences and their outcome consistent with requirements under Article IV of these bylaws.

(4) Contribute to, and abide by, high standards of ethics in professional practice and conduct applicable to the individual's discipline of training e.g. AMA, ADA etc.

(5) Abide by the process for supervision of participants in the professional graduate education programs.

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

ARTICLE IV

APPOINTMENT AND INITIAL CREDENTIALING

SECTION 1 General Provisions

1. All eligible members of the medical staff as defined in Article III, Section 1, are subject to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges. Credentials that are subject to change during leaves of absence, in excess of 30 days, will be subjected to review at the time the individual returns to duty.

2. Appointments to the medical staff occur in conjunction with VA employment or utilization under a VA contract or sharing agreement. The authority for these actions is based upon:

a. Provisions of 38 U.S.C. in accordance with Department of Veterans Affairs Handbook 5005, part II, chapter 2 and its supplements, Part I, Appendix 338A and applicable Agreement(s) of Affiliation in force at the time of appointment.

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

3. **Probationary Period**. As used in this document, refers to status as an employee and is independent of delineation of clinical privileges. Initial and certain other appointments made under 38 U.S.C. 7401 (1), 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 and procedures. If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply similar processes to the evaluation of individuals employed under provisions of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.

4. **Provisional Period**. All initial appointments are considered provisional for the first two years following initial appointment. During this period, professional competency, performance and conduct will be closely assessed by the Service Chief with evaluation on an annual basis or more frequently if indicated.

SECTION 2 Application Procedures

1. Applicants for appointment to the medical staff and applicants for clinical privileges must submit a complete application, through VetPro. APRNs as allowed by their state licensure, will follow the same credentialing and privileging process as outlined in these bylaws. Physician Assistants (PA) will be credentialed only and will work under a scope of practice.

a. Items specified in Article III, Section 1, Membership Eligibility; and Section 2, Qualifications for Clinical Privileges.

b. **References**. Names and addresses of a minimum of three (3) practitioners in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice. These peer references will be asked to address the applicant's medical/clinic knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism. At least one of the work history references must be from the current or most recent employer(s) or institution(s) where clinical privileges are/were held. In the case of new applicants who are just completing residencies, one peer reference must come from the residency program director.

c. **Previous Employment**. List of all health care institutions where the LIP is/has been appointed, utilized or employed, including:

(1) Name of health care institution or practice;

(2) Term of appointment or employment; and

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

d. **DEA (Drug Enforcement Administration) registration**.

(1) For those who have, or have had, DEA registration; and

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

e. Challenges to license, including whether a license or registration ever held to practice by the LIP has been suspended, revoked, voluntarily/involuntary surrendered or not renewed.

f. Status of any claims made against the LIP in the practice of any health occupation including final judgments or settlements.

g. Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

h. Previously successful or pending challenges against the LIP by any hospital, licensing board, law enforcement agency, professional group or society.

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

j. Conviction of a felony in state or federal court.

k. Verification of individual identity, by authorized photo I.D.

2. Documents required in addition to those required from the applicant include:

a. A minimum of three reference letters from individuals able to provide authoritative information regarding the individual's training/experience, professional competence and conduct and health status.

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

c. Verification of status of licenses for all states in which the applicant has ever held a license. State Licensing Boards WEB sites may be used, per The Joint Commission, if past disciplinary issues are stated.

d. For foreign medical graduates, evidence and verification of the ECFMG certificate.

e. Evidence and verification of board certification.

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

g. Reports of queries or evidence of submission of query to National Practitioner Data Bank (NPDB), Office of Inspector General (OIG), and Federation of State Medical Boards (FSMB), for all members of the medical staff and those LIPs with clinical privileges.

h. Confirmation of health status by Declaration of Health document, or if staff position, by required physical examination.

i. Agreement to Bylaws, Rules and Regulations and to provide continuous care of applicant's patients.

3. Effort will be made to verify, with primary sources or designated equivalent sources, all credentials claimed. A good faith effort to verify is defined as two documented requests, either written or oral.

4. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant 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 in 60 days may serve as a basis for denial of appointment consideration.

5. False, Misleading, or Omitted Information. Failure of the applicant to provide information or to cooperate as requested in order to process the application, or provision of false or misleading information by an applicant constitutes a basis for denial of appointment or reappointment or revocation of a medical staff appointment. The applicant shall have the burden to update the information provided in the application regarding any changes or additional information arising during the pendency of the review of the application.

SECTION 3 **Process and Terms of Appointment**

1. The Chief of the service to which the applicant is to be assigned is responsible for recommending appointment to the medical staff based on evaluation of the applicant's credentials and determination that department criteria for clinical privileges are met.

a. Individuals in administrative positions are appointed or reappointed through the same procedure used for all other members of the medical staff.

b. In the case of individuals functioning in administrative and/or patient care capacities in the medical center pursuant to a contract or faculty appointment, continued medical staff membership may or may not be made contingent on continuance of the contract or faculty appointment.

c. Individuals who provide patient care functions via telemedicine link are subject to the same processes used for all other members of the medical staff.

d. The CEB recommends medical staff appointment based on the recommendation of the Credentialing Committee.

e. Appointments to the medical staff will be acted upon by the Medical Center Director within 30 days of receipt of a fully complete application inclusive of all required verifications, references and recommendations from the appropriate Service Chief and CEB.

f. Candidates for appointment who have submitted complete applications as defined by these Bylaws, Rules and Regulations will receive written notice of appointment or non-appointment, by the Medical Staff Office. In the case that appointment is not approved, the basis for the action will be briefly stated.

g. The Medical Center Director is the approving official for all appointments to the medical staff.

h. Medical staff appointment is granted for a period of no more than two years at a time.

2. **Temporary/Expedited Appointment**

a. When there is an emergent or urgent patient care need, a temporary/expedited VA appointment, under the provisions of VHA Handbooks 1100.19 and 5005, appointment may be approved by the Medical Center Director upon recommendation of the Chief of Staff prior to action by CEB.

b. A completed VetPro credentialing application, and verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted, NPDB query, OIG exclusions check, FSMB query, and a peer reference will be obtained prior to making such an appointment

c. The Medical Center Director will document for the record the specific patient care situation that warranted such an appointment. Temporary appointments will not exceed 45 days, or less, as deemed by the approving authority.

d. The following are evaluated on a case-by-case basis for temporary/expedited appointments and usually result in ineligibility for the expedited process:

(1) A current challenge or previously successful challenge exists, to licensure or registration;

(2) Applicant has received involuntary limitations, reduction, denial or loss of clinical privileges at another facility;

(3) Applicant has received involuntary termination of medical staff membership, at another facility; or

(4) There are unusual patterns of professional liability actions, in final judgment against applicant.

ARTICLE V

CLINICAL PRIVILEGES

SECTION 1 General Provisions

1. Medical center specific clinical privileges are granted for a period of no more than two years. It is the responsibility of the LIP to assure that all documentation necessary for completion of renewal is available at least 60 days from the date of notification of renewal. It is the responsibility of the medical center to complete the process prior to the expiration date in order to prevent a lapse in the LIP's authority to treat patients. Applicants for privileges will be kept apprised of the status of their application and involved in clarification of issues, as appropriate. Failure to provide the necessary paperwork required for renewal of privileges will result in lapse of the LIP's clinical privilege status and the individual will have to reapply for clinical privileges.

2. Biennial reappraisal of each LIP is required**.** Reappraisal includes a review of credentials, performance including provider specific PI information, clinical and technical skills, professional judgment, evaluation of the individual's physical and mental status, and an assessment of the individual's current privileges. It also requires satisfactory completion of continuing education, and demonstration of continued competency for specific privileges requested. Reappointment verification includes query of the NPDB, OIG list and verification of all state licenses.

3. An LIP's request for modification/enhancement of existing clinical privileges is made by LIP submission of a formal request to the Credentialing Committee through the Service Chief to the CEB the desired change(s) with full documentation to support the change.

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

5. LIPs with clinical privileges are assigned to and have clinical privileges in one clinical department, but may be granted clinical privileges in other clinical departments subject to meeting the standards of the department and with concurrence of Service Chief and the CEB and as approved by the Medical Center Director.

6. Exercise of clinical privileges within any department is subject to the rules of that department and to the authority of the Service Chief. Each clinical department will establish and maintain the criteria, which will be the basis upon which clinical privileges will be extended to members of the department. Granted clinical privileges are relevant to the care provided in the department.

7. If medical staff appointment is not a result of an affiliate faculty appointment, the LIP has the option of not participating in the teaching program without jeopardizing their clinical privileges.

8. Privilege delineation is based on experience and the LIP's credentials record.

9. Physicians or oral surgeons can be the attending physician for patient admission to inpatient care when privileged to do so.

10. LIPs, when privileged to do so, may order admission to the hospital.

11. Treatment or direction of treatment of patients is limited to the delineated privileges for an individual LIP. Privileges not granted may not be exercised.

SECTION 2 Process and Requirements for Requesting Clinical Privileges

1. Burden of Proof: The LIP requesting clinical privileges must furnish all information needed for a proper evaluation of professional competence, conduct, ethics, judgment, clinical or technical skills, and other qualifications. The information must be complete and verifiable. The LIP is responsible for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 60 days may serve as a basis for denying clinical privileges.

2. All LIP requests for clinical privileges must initially be forwarded to the appropriate Service Chief, who will review and evaluate request, then service will forward a memo to the Medical Staff Office requesting that the credentialing and privileging processes begin.

3. The LIP applying for initial clinical privileges must submit a complete application for privileges, which will include:

   a. Complete appointment information as outlined in Section 2 of Article IV; and

b. Application for clinical privileges as outlined in Section 2, of Article IV.

4. The LIP applying for renewal of clinical privileges subsequent to those granted initially will provide the following information:

a. An application for clinical privileges as outlined in Section 2, of Article IV;

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

c. Physical and mental health status as it relates to LIP's ability to function within privileges requested, including such reasonable evidence of health status that may be required by the Credentialing Committee;

d. Documentation of continuing medical education related to area and scope of clinical privileges, not previously submitted;

e. Status of all licenses, certifications held;

f. Any sanction(s) by a hospital, state licensing agency or any other professional health care organization, challenges to any licensure or registration, voluntary or involuntary relinquishment of licensure or registration, any malpractice claims, suits or settlements (those in process and final judgments), voluntary or involuntary termination of medical staff membership, reduction or loss of privileges at any other hospital. Detailed information should be provided regarding all actions taken. Regarding closed or settled malpractice claims, final judgment or settlement information is required;

g. Response time to facility for on call status remains no more than 30 minutes;

h. Names of other hospitals at which privileges are held and copies of the privileges held; and

i. A minimum of two (2) peer recommendations.

5. Bylaws, Rules and Regulations Receipt and Pledge. Prior to the granting of clinical privileges, LIPs will pledge in writing to provide for continuous care of their patients and will receive a copy of the Bylaws, Rules and Regulations and agree to abide by the professional obligations therein.

6. Verification

a. Verification of credentials prior to granting of initial privileges will be accomplished as described in Article IV, Appointment and Initial Credentialing. Information will be verified through primary source or designated equivalent source.

b. Before granting renewal of clinical privileges, the Chief of Staff will assure that the following information is on file and verified with primary sources, as applicable:

(1) Current and former licenses in all states;

(2) Current and former DEA license and/or registration;

(3) National Practitioner Data Bank query;

(4) Physical and mental health status information from applicant;

(5) Physical and mental health status confirmation and professional competence information from peers, authoritative individuals from hospitals in which privileges are held, or service chief;

(6) Continuing education to meet any local requirements for privileges requested;

(7) Board certification(s) or other eligibility;

(8) Provider specific quality of care information; and

(9) Office of Inspector General's (OIG) exclusionary list.

7. Advanced Practice Registered Nurse (APRN)

APRNs will be granted clinical privileges as LIPs, within the scope of their individual state licensure. The Nurse Professional Standards Board will review their credentials and forward the recommendation for appointment through the Credentialing Committee. The Credentialing Committee will recommend clinical privileges to the CEB and the Medical Center Director for approval.

SECTION 3 Credentials Evaluation and Maintenance

1. Determination will be made (through evaluation of all credentials, peer recommendations, and continuous performance improvement information) that the LIP applying for clinical privileges, has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested as submitted from the Service Chief to the Credentialing Committee.

2. Effort will be made to verify with primary sources, or designated equivalent sources, all credentials claimed. A good faith effort to verify is defined as two documented attempts to secure the information. Before granting clinical privileges, the Organized Medical Staff, through the Credentialing Committee, evaluates:

a. Challenges to any state licensure or registration;

b. Voluntary and involuntary resignation of any license or registration;

c. Voluntary and involuntary limitation, reduction, or loss of clinical privileges;

d. Voluntary and involuntary termination of medical staff membership;

e. Any unusual pattern of professional liability actions, resulting in judgments against applicant;

f. Documentation of applicant's health status;

g. Relevant provider specific quality improvement data; and

h. Morbidity and mortality data, when available.

3. The credentials of LIPs transferring from one VA Medical Center to another must be transferred in the electronic VetPro system and the hard copy Credentialing and Privileging Folder will be sent to the receiving medical center. In addition, the receiving medical center will verify (primary source) all licensure and NPDB information.

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

SECTION 4 Recommendations and Approval

1. Peer recommendations will be obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice. Peer recommendations include the following information: Medical/Clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills and professionalism. Sources for peer recommendations may include: a hospital performance improvement committee, the majority of whom are the applicant's peers; reference letters, written documentation or documented telephone conversations about the applicant from a peer who is knowledgeable about the applicant's performance and competence; a department or clinical service chairperson who is a peer; or documentation, either written or oral, from a medical staff executive committee.

2. The Service Chief to whose department the applicant for clinical privileges is assigned is responsible for assessing all information and recommending approval of clinical privileges.

a. Recommendation for initial privileges will be based on determination that applicant meets criteria for clinical privileges for the department including requirements regarding education, training, experience, references and ability to perform clinical privileges requested as well as confirmation of adherence to requirements stated in Medical Staff Bylaws, Rules, and Regulations and policies.

b. Recommendation for renewal of clinical privileges or for additional clinical privileges subsequent to those initially granted will be based on, at least, reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment and clinical and/or technical skills and quality of care including results of professional practice evaluation activities. Ongoing information will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal.

3. The CEB recommends granting of initial and renewal of clinical privileges based on each applicant's successfully meeting the requirements for clinical privileges as specified in these Bylaws. In instances where there is doubt about an applicant's ability to perform the privileges requested, an evaluation by someone other than the applicant's chairperson or chief of service may be requested by the CEB to resolve the issue.

4. Clinical Privileges are acted upon by the Medical Center Director within 30 days of receipt of a fully complete application for clinical privileges that includes all requirements set forth in Article V, Section 2.

5. Original documents of approved clinical privileges are placed in the individual LIP's Credentialing and Privileging Folder and are entered, in summary, into VISTA for access by medical center staff responsible for monitoring scope of practice activities. Copies are distributed to the LIP.

SECTION 5 Exceptions

1. **Temporary Clinical Privileges (Expedited Process)**

a. Temporary privileges may be granted to fulfill an important patient care, treatment and services need. The temporary privileges may be granted for a limited period of time not to exceed 45 working days from the time of LIP signing by the Medical Center Director, on the recommendation of the Chief of Staff.

b. Temporary privileges will be based on documented evidence of a current state license and other reasonable, reliable information concerning training and current competence related to the privileges to be granted. The information needing to be verified includes:

(1) Current licensure;

(2) Relevant training and experience;

(3) Current competencies;

(4) Ability to perform privileges requested;

(5) NPDB query;

(6) FSMB query;

(7) Completed VetPro temporary application;

(8) No current or previous successful challenge to licensure or registration;

(9) No involuntary termination of medical staff membership, at another facility;

(10) No limitation, reduction, denial or loss of clinical privileges; and

(11) One peer reference.

2. **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.

3. **Disaster Privileges**:

a. In circumstances of disaster events, in which the emergency management plan has been activated, and the medical center is unable to handle the immediate patient needs, the Medical Center Director or Chief of Staff, may grant disaster privileges, on a case by case basis, to volunteer licensed independent practitioners (LIPs) upon presentation of a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and any one of the following:

(1) A current hospital picture ID card that clearly identifies professional designation;

(2) A current license to practice;

(3) Primary source verification of the license;

(4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); a Medical Reserve Corps (MRC); the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program; or other recognized state or federal response organization or group;

(5) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); and/or

(6) Confirmation by a LIP currently privileged by the LVAMC or by a LVAMC staff member with personal knowledge of the volunteer practitioner’s ability to act as a LIP during a disaster.

b. During a disaster, the medical staff oversees the performance of each volunteer LIP. Volunteer LIPs with disaster privileges will be placed under the supervision of a medical staff member who will oversee their performance by direct observation or medical record

review. A decision will be made as soon as situation is under control, or not longer than 72 hours of the practitioner's arrival if granted disaster privileges should continue. Disaster privileges may not exceed ten calendar days or the length of the declared disaster, whichever is shorter. At the end of this period, the LIP needs to be converted to Temporary privileges, as defined by hospital policy. If primary source verification of a volunteer LIP licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Chief of Staff or designee will document all of the following:

(1) Reason(s) it could not be performed within 72 hours of the practitioner's arrival;

(2) Evidence of the LIP's demonstrated ability to continue to provide adequate care, treatment and services.

(3) Evidence of the hospital's attempt to perform source verification as soon as possible.

c. The Emergency Management Coordinator will have a mechanism to distinguish between volunteer LIPs from staff LIPs.

d. The verification process of the credentials and privileges of individuals who receive disaster privileges is considered a high priority, and is initiated as soon as the immediate situation is under control.

4. **Telemedicine**:

a. LIPs who have either total or shared responsibility for the care of a specific patient, through a telemedicine link, are fully credentialed and privileged.

b. Under certain circumstances, the VAMC can, as the originating site (where the patient is located), accept the credentialing and privileging documentation of the distant site (where the provider providing the care/consulting is located). The originating site may use the credentialing and privileging information from the distant site if:

(1) The distant site is accredited by The Joint Commission; and

(2) The provider is privileged, as an LIP, at the distant site for services being provided.

(3) The originating site has evidence of an internal review of the performance of these privileges and performance improvement, and sends this information to the distant site. At a minimum, this information must contain the following:

(a) All adverse events related to telemedicine services; and

(b) Complaints about the distant site provider from patients, other LIPs, staff at the originating site.

ARTICLE VI

FAIR HEARING AND APPELLATE REVIEW

SECTION 1 Denial of Medical Staff Appointment

When review of credentials and recommendations contained in a complete application result in denial of appointment, the applicant will be notified by the chairperson of the Clinical Executive Board (CEB) in a letter over the signature of the Medical Center Director. The notification will briefly state the basis for the action. The applicant may appeal denial of the appointment, in writing, to the Medical Center Director.

SECTION 2 Actions Against Clinical Privileges

1. When recommendations regarding clinical privileges are adverse to the applicant, including but not limited to reduction and revocation, procedures in VHA policy on credentialing and privileging will be followed and will include: assessment of the individuals documented performance; non-use of privileges for high-risk procedure or treatment over the two year period; and change of clinical privileges based on emergence of new technology.

2. Privilege changes based on disciplinary action and/or performance are undertaken after due process procedures consistent with those outlined in VHA policy on credentialing and privileging.

3. **Summary Suspension:**

a. Summary suspension of privileges on a temporary basis, may be made by the Medical Center Director, on the recommendation of the Chief of Staff, pending the outcome of a formal action or investigation when there is sufficient concern regarding patient safety or inappropriate practice patterns, consistent with the requirements in VHA regulations on Credentialing and Privileging. The summary suspension pending investigation is not reported to the NPDB. Final action arising from the investigation following summary suspension that adversely affects privileges for a period longer than 30 days is reportable to the NPDB.

b. The involved LIP will receive notice from the Medical Center Director and the Chief of Staff, that privileges are summarily suspended. The LIP will be temporarily reassigned to an administrative position or placed on administrative leave. The Chief of Staff will initiate a timely investigation. If the findings of the investigation support the charges, appropriate disciplinary action will be taken. If findings do not support the charges, the LIP will be returned to full privileges. Indications for summary suspension of clinical privileges include, but are not limited to, the following:

(1) Significant deficiencies in clinical practice such as lack of diagnostic or treatment capability; multiple errors in transcribing, administering or documenting medications, inability to perform clinical procedures considered basic to the performance of one's occupation or performing procedures not included in one's clinical privileges in other than emergency situations;

(2) Patient neglect or abandonment;

(3) Mental health impairment sufficient to cause the individual to make judgment errors affecting patient safety, to behave inappropriately in the patient care environment or to provide unsafe patient care.

(4) Physical health impairment sufficient to cause the individual to provide unsafe patient care;

(5) Substance abuse when it affects the individual's ability to perform appropriately as a health care provider or in the patient care environment;

(6) Falsification of credentials;

(7) Falsification of medical records or prescriptions;

(8) Theft of drugs;

(9) Inappropriate dispensing of drugs;

(10) Unethical behavior;

(11) Patient abuse , including mental physical, sexual and verbal abuse and including any action or behavior that conflicts with a patient's rights identified in Title 38, code of Federal Regulations (CFR); intentional omission of care; willful violations of a patient's privacy; willful physical injury, or intimidation,. Harassment or ridicule of a patient; and or

(12) Falsification of research findings.

4. **Automatic (Administrative) Suspension:** The Medical Center Director, on the recommendation of the Chief of Staff, may automatically (administratively) suspend privileges for any provider upon the occurrence of a specific event(s) that does not require an investigation of clinical care concerns. The involved LIP will receive notice from the Medical Center Director and the Chief of Staff, that privileges are automatically (administratively) suspended. The LIP will be temporarily reassigned to an administrative position or placed on administrative leave. The Chief of Staff will initiate a timely investigation. If the findings of the investigation support the charges, appropriate disciplinary action will be taken. If findings do not support the charges, the LIP will be returned to full privileges. Indications for Automatic (Administrative) suspension of clinical privileges include, but are not limited to, the following:

a. Being investigated, indicted, or convicted of a misdemeanor or felony that could impact the quality and safety of patients.

b. Failure to complete medical records in accordance with hospital policy.

c. Failure to complete required mandated VA training.

d. Failure to renew licensure.

e. Falsification of any employment documents and or credentials.

f. Conduct/behavior issues not impacting patient care

g. Failure to maintain the mandatory requirements for membership to the medical staff.

5. Mechanisms for fair hearing and appeals process for adverse decisions are found in Appendix B of the bylaws. The process for fair hearing and appeal is the same for all medical staff members.

SECTION 3 Self-Governance Actions

1. The medical staff has a responsibility to identify and manage matters of individual LIP's health. The goal is to aid an LIP in retaining or regaining optimal professional functioning consistent with protection of patients. This is separate from medical staff disciplinary function.

2. Educational efforts are directed at both the medical staff and medical center staff in areas of physician/practitioner health and addresses prevention of physical, psychiatric and emotional illness.

3. Physicians/LIPs can self-refer to medical staff leadership for assistance. Other organizational staff may refer an individual physician/LIP to medical staff leadership for evaluation and/or assistance. In such a case, the credibility of the complaint, allegation or concern will be evaluated.

4. For LIPs who suffer from a potentially impairing condition, assistance is given to aid the LIP in retaining or regaining optimal professional functioning consistent with protection of patients. Opportunity is given to participate in the Employee Assistance Program or through other appropriate internal or external resources for diagnosis and treatment of the condition or concern. In such cases, diagnosis, evaluation, treatment and rehabilitation will be kept confidential except as limited by law, ethical obligation, or when the safety of a patient is threatened. The affected physician and the safety of patients will be monitored until the rehabilitation or any disciplinary process is complete.

5. In those instances where competency to perform clinical privileges is uncertain, the following possible actions will be made available to the LIP:

a. Accept a tutorial/supervised clinical experience by a fully credentialed peer for periods no less than three months and not to exceed one year after which the clinical privileges will be considered. Documentation of both the qualitative and quantitative performance must be presented and a statement requiring proficiency will also be provided to the CEB.

b. Participate in additional CME or course requirements which will be established on a case-by-case basis and be the responsibility of the LIP.

6. It should be understood that the mere completion of any of the above processes without additional evidence of improvement in performance as measured by peer specific quality assessment methods (i.e., case review) would not automatically provide for retention or restoration of privileges.

7. If at any time during the diagnosis, treatment or rehabilitation phase of the process it is determined that an LIP is unable to safely perform the privileges granted, the matter is forwarded to the Credentialing Committee for appropriate corrective action that includes strict adherence to state and federally mandated reporting requirements.

SECTION 4 Reporting Adverse Actions

1. Disclosure of information to State licensing boards regarding LIPs separated from VA service will be completed under the provisions of VHA regulations.

2. Disclosure of information to the NPDB and to state licensing boards regarding adverse action against clinical privileges of more than 30 days, including the surrender of clinical privileges or any voluntary or involuntary restriction of such privileges while the LIP is under investigation, will follow provisions of the VHA policy on National Practitioner Data Bank - Reports. Summary suspension pending comprehensive review and due process is not reportable to the NPDB. However, the notice of summary suspension to the LIP will include a notice that if final action is taken, it will be reported to the NPDB. The notice of summary suspension will also contain information on the individual's due process rights.

SECTION 5 Reporting Malpractice Payments

Disclosure of information regarding malpractice payments determined by peer review to be related to substandard care, professional incompetence or professional misconduct on the part of an LIP will follow provisions of the VHA policy on National Practitioner Data Bank.

SECTION 6 Termination of Appointment

Termination of medical staff appointments will be accomplished in conjunction with, and follow procedures for, terminating appointments of LIPs set forth in Federal and VA Acquisition Regulations (FAR); and other applicable VHA policies and regulations.

ARTICLE VII

ORGANIZATION OF THE MEDICAL STAFF

SECTION 1 Officers

VA has no requirement for "Officers" of the medical staff.

SECTION 2 Leadership

1. The Chief of Staff functions as the President of the medical staff.

2. The Chief of Staff is fully responsible to the Medical Center Director for all programs of patient care and for the educational and research activities of the clinical departments. Aspects include: formulations of plans for a comprehensive program of medical care, continuous performance improvement, requirements of staff, facilities, equipment and supplies needed to carry forth the programs including utilization of necessary reviews and controls and budgetary requirements; appraisal of the effectiveness of the various medical programs in meeting the needs of patient care.

3. The medical staff, through its committees, departments and Service Chiefs, provides counsel and assistance to the Chief of Staff and the Medical Center Director regarding all facets of the patient care services and programs, including continuous quality improvement activities, patient safety and satisfaction, goals and plans, mission, and services offered and assures that accepted management practices are maintained throughout the clinical departments.

4. The Chief of Staff represents the medical staff on the Academic Partnership Council and is the professional liaison of the Medical Center with this partnership and consultant groups.

5. The Clinical Executive Board (CEB) is the executive committee of the medical staff, chaired by the Chief of Staff, and serves as an advisory board to the Medical Center Director.

SECTION 3 Graduate Medical Education

1. The Organized Medical Staff is responsible for the oversight of the graduate medical education program activities at the Louisville VA Medical Center. Members of the medical staff with an affiliate appointment provide administrative and clinical supervision of house staff and trainees. Supervision roles and responsibilities of patient care activities are governed by the guidelines established by the VA and affiliates.

2. The University of Louisville Graduate Medical Education Committee serves as the communication link to the organized medical staff about quality of patient care, treatment and services and educational needs of the participants. At least one member of the organized medical staff is appointed to this committee. Minutes of their meetings are provided to the CEB for review and action as appropriate.

ARTICLE VIII

COMMITTEES

SECTION 1 Executive Committee of the Medical Staff – Clinical Executive Board

1. The Clinical Executive Board (CEB) is the Executive Committee of the medical staff and is empowered to act on behalf of the medical staff between medical staff meetings of the whole. The CEB carries out its work within the context of the medical staff functions of governance, leadership, and PI activities. The CEB serves as an advisory board to the Medical Center Director.

2. The CEB is defined by medical center policy. The CEB is the executive committee of the medical staff, chaired by the Chief of Staff, and empowered to act on behalf of the medical staff between formal meetings of the medical staff. It carries out its work within the context of the medical staff functions of governance, leadership and performance improvement activities. The CEB reports to the Joint Conference Council. The board will include clinical service chiefs (including Pharmacy), Associate Chiefs of Staff, active medical staff members who have been elected to the "at large" positions by the medical staff, the Chair of the Credentialing Committee, the Associate Director for Patient Care Services, the Medical Center Director or designee, the Chief of Quality Management Service, the Medical Staff Coordinator, an advanced practice registered nurse, and a doctoral level psychologist. In specified instances, as outlined in VHA directive or result of a DoD Sharing Agreement, the Service Chief is permitted to be a non-physician. In those instances, physician members of that service will be represented on the CEB by a supervisory level physician from that service.

3. The Chief of Staff and active staff members serving on the CEB do so by status of their position held at the medical center. Change in either active medical staff membership or position appointment would result in removal from the CEB.

4. The members-at-large to the CEB are active medical staff members who are nominated by the active staff members from among the active staff members. At the annual medical staff meeting, two members-at-large will be voted upon to serve a two-year term on the CEB. The term will coincide with the academic year (July through June). The at-large member may serve consecutive terms if so elected. The majority of voting CEB members are fully licensed physician members of the medical staff actively practicing at the medical center.

SECTION 2 Standing Committees

1. Standing committees provide a major framework by which the medical staff accomplishes performance improvement functions for clinical processes. These committees meet on a frequency basis as determined by the Clinical Executive Board and medical center policy. Committees prepare and maintain records of discussion, conclusion, recommendations, actions and results of actions taken and are responsible for timely communication of committee activities through channels established by the medical staff.

2. Standing committees are defined in medical center policy and include; Academic Partnership Council, Bylaws Committee, Cancer Committee, Clinical Informatics Committee, Clinical Products Review Committee, Credentialing Committee, Critical Care Multidisciplinary Committee, Dementia Committee, Disruptive Behavior Committee, Graduate Medical Education Committee, Health Information Management Review Committee, Home Respiratory Care Program Committee, Infection Control Committee, Mental Health Executive Committee, Nutrition Committee, Out-of-Operating Room Procedure Committee, Peer Review Committee, Pharmacy and Therapeutics Committee, Preservation-Amputation Care in Veterans Everywhere (PAVE) Committee, Radiation Safety Committee, Research and Development Committee, Stroke Care Committee, Surgical Quality/Operating Room Review Committee, Tissue Committee, Transfusion and Tissue Utilization Committee, and Women Veterans Health Care Committee.

SECTION 3 **Committee Attendance**

1. Medical staff members will attend committee meetings of which they are members unless specifically excused by the committee chairperson for appropriate reasons, e.g., illness, leave, and clinical requirements. Committee minutes will specify members absent, alternates and members present. Unexcused absences will be reported to the appropriate service chief and the CEB Committee chair for subsequent action.

ARTICLE IX

CLINICAL DEPARTMENTS

SECTION 1 **Characteristics**

1. Organized to carry out services under the effective leadership of the Service Chief.

2. Provides patient care according to its written goals and Scope of Services for the department as approved by the Clinical Executive Board (CEB) and Medical Center Director.

3. Holds regular departmental staff meetings.

SECTION 2 **Functions**

1. Assist in identification of important aspects of care for the department, identification of indicators used to monitor quality and appropriateness of important aspects of care, and evaluation of the quality and appropriateness of care including efficiency of clinical practice patterns and significant departures from established patterns of clinical practice.

2. Provide for continuous quality improvement within the department to include findings of ongoing monitoring and evaluation of quality (including access, efficiency, and effectiveness), appropriateness of care and treatment provided to patients, patient satisfaction activities, risk management activities, patient safety and utilization management.

3. Maintain records of meetings that include conclusions, recommendations and actions taken.

4. Develop criteria for recommending clinical privileges for its members.

5. Develop clinical privileges statements, functional statements, and define the scope of services for the department.

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

SECTION 3 **Selection and Appointment of Service Chiefs**

Service Chief recruitment and selection will be as outlined in VHA policy. Service Chiefs shall be board certified by the appropriate specialty board or provide evidence of equivalent training, experience and competence. In those instances, as outlined in VHA directive or as a result of a DoD sharing agreement, where the clinical service chief does not meet the training requirements to qualify as an active member of the medical staff, the supervisory level physician in the service will provide guidance to the clinical service chief in all aspects pertaining to professional performance and clinical privileges of LIPs.

SECTION 4 **Duties and Responsibilities of Service Chiefs**

1. Service Chiefs provide effective leadership for all functions of the department and are responsible and accountable for:

a. All clinically related activities of the department. Monitoring and evaluating the quality of care provided by the service. This includes access, efficiency, appropriateness and effectiveness of care and treatment of patients;

b. All administratively related activities of the department, unless otherwise provided by the medical center;

c. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

d. Recommending to the medical staff the criteria for clinical privileges that are directly related to the care provided in the department including levels or categories of care when used;

e. Recommending appointment/reappointment for each medical staff member of the department and approval/renewal of clinical privileges for each LIP in the department utilizing criteria that are directly related to quality of care;

f. Assessing and recommending to the COS off-site sources for needed patient care services not provided by the department or the organization including development and review of work statements for contract services proposed;

g. Assessing and recommending to the medical staff any clinical services that can be appropriately delivered through a telemedicine link, according to commonly accepted quality standards;

h. The integration of the department into the primary functions of the organization;

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

j The development and implementation of policies and procedures that guide and support the provisions of services including: a process for the update of department specific and related department medical center memoranda; definition of diagnostic and therapeutic interventions that are high risk; identification of critical test values performed by the service; procedures and clinical privileges that are setting specific;

k. The recommendations for a sufficient number of qualified and competent persons to provide care or services;

l. The determination of the qualifications and competence of department personnel who are not LIPs and who provide patient care services. This includes pre- employment evaluation to determine the competency of the individual before assuming patient care responsibility;

m. The continuous assessment and improvement of the quality of care and service provided and communication of such activities to its staff members;

n. The maintenance of quality control programs, as appropriate;

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

p. Recommendations for space and other resources needed by the department;

q. Assuring appropriate supervision of House Staff assigned to the department consistent with rules, regulations, and policies;

r. Participation as a member of the CEB; and

s. Supervision and identification of LIPs who have been granted disaster privileges when the Medical Center Director has activated the Emergency Management Plan.

ARTICLE X

MEDICAL STAFF MEETINGS

1. The medical staff meets as a whole at least annually convened at the call of the Chief of Staff.

2. Special meetings may be convened at the call of the Chief of Staff.

3. Department specific medical staff meetings are convened upon call of the Service Chief.

4. Active medical staff members will attend department specific medical staff meetings unless specifically excused by the Service Chief for appropriate reasons.

5. Minutes of all meetings will reflect attendance, absences, issues discussed, conclusions, actions, recommendations.

ARTICLE XI

RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws and guidelines of the Governing Body, subject to approval of the facility Director. Such rules and regulations shall be a part of these Bylaws. Rules and regulations may be adopted, amended or repealed by an affirmative vote of the majority of those active medical staff members voting or by a
three-fourths vote of the CEB after the proposed changes have been brought up and discussed at a previous CEB meeting. Such changes shall become effective when approved by the facility Director. Rules of departments or services will not conflict with each other, with bylaws and policies of the medical staff or requirements of the Governing Body.

ARTICLE XII

AMENDMENTS

1. The Bylaws, Rules and Regulations are reviewed at least annually, 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, Rules and Regulations and attendant policies may be submitted in writing to the Medical Center Director or the Chief of Staff by any service chief or member of the medical staff. Proposed changes will be submitted to the appointed Bylaws Committee who will review and present all changes to the Clinical Executive Board (CEB) for concurrence and presentation to the medical staff as a whole. The CEB may make changes as necessary with proposed changes presented to the full medical staff.

2. If conflict exists on issues including, but not limited to, proposals to adopt a rule, regulation or policy or an amendment thereto, medical staff members have a right to submit the issue in writing to the Medical Center Director. The Medical Center Director will review the conflict and request the CEB to review the conflict and provide a response to the Medical Center Director. The Medical Center Director will notify the medical staff member(s) of his/her decision. If the Medical Center Director affirms the current Bylaws, Rules and Regulations, no other action will be taken. If the Medical Center Director recommends reconsideration/revision following CEB review, the proposed changes will be submitted to the medical staff as a whole for a new vote.

3. Written text of proposed significant changes are to be provided to medical staff members. Medical staff members will be given a minimum of 30 days to review and vote on proposed changes. Voting will occur electronically. Approval or rejection of the proposed amendment will be based on a majority vote of those voting on the proposed change.

4. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, CEB may provisionally adopt and the Medical Center Director may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff will have the opportunity for retrospective review of and vote on the provisional amendment. If the provisional amendment is not rejected by a majority of the medical staff voting, the provisional amendment stands. If there is conflict over the provisional amendment, medical staff members have the right to submit the conflict in writing to the Medical Center Director. The Medical Center Director will review the conflict and request the CEB to review the conflict and provide a response to the Medical Center Director. The Medical Center Director can request the amendment be revised, if necessary, and submit to the medical staff for vote. The Medical Center Director will notify the medical staff members of his/her decision on the matter.

5. All changes to the Bylaws, Rules and Regulations require action by both the medical staff and Medical Center Director. Neither may amend unilaterally.

6. Changes are effective when approved by the Medical Center Director.

ARTICLE XIII

ADOPTION

These Bylaws, Rules and Regulations, together with the appended Bylaws, Rules, and Regulations shall be adopted upon recommendation of the medical staff at the annual meeting or special meeting of the active medical staff or Clinical Executive Board at which a quorum is present; shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Medical Center Director.

RECOMMENDED:

_____

Marylee Rothschild, M.D., MPH Date
Chief of Staff

APPROVED:

_____

Martin J. Traxler Date
Medical Center Director

RULES AND REGULATIONS

GENERAL

1. The rules and regulations relate to role and/or responsibility of members of the medical staff, and to individuals with patient care functions as defined by the individual's scope of practice and functional statement in the care of inpatients, emergency care patients and ambulatory care patients. Changes to the rules will be produced by the respective service and forwarded to the Medical Staff Office for presentation to the Bylaws Committee, and at the annual staff meeting, or as acted on by the Clinical Executive Board (CEB), on behalf of the medical staff between official medical staff meetings, of the whole. Medical staff rules are effective after the approval of the Medical Center Director.

2. VHA rules, regulations and directives, and medical center memoranda and associated policies will not conflict with each other, the Medical Staff Bylaws, or with Governing Body requirements. All privileged providers will be provided a copy of the rule and regulation changes, as they occur.

3. Medical Center Memoranda (MCM) are considered an extension of the rules and are available for review.

4. All LIPs are subject to the performance improvement mechanism designed to ensure that a uniform level of quality care, treatment, and services is provided by all individuals with delineated clinical privileges, within medical staff departments and across departments.

PATIENTS RIGHTS

1. The medical center supports the rights of each patient and publishes policy and procedures to address rights including:

a. Reasonable response to requests and need for service within capacity, mission, laws and regulations;

b. Considerate and respectful care;

c. Collaboration with physician in matters regarding personal health care;

d. Formulation of advance directives and appointment of surrogate to make health care decisions;

e. Access to information necessary to make care decisions that reflect patient's wishes;

f. Access to information about patient rights, handling of patient complaints;

g. Participation of patient or representative in consideration of ethical decisions regarding care;

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

i. Personal privacy and confidentiality of information;

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

k. Foregoing or withdrawing life-sustaining treatment including resuscitation;

l. Access to the medical center as a conduit to protective services in cases of child/elder abuse and domestic violence; and

m. Comprehensive approach to pain assessment and management;

ADVANCED DIRECTIVES

1. Patients' advanced directives will be honored as specified in medical center policy. Patients have the authority to accept and/or refuse medical care. Patients' wishes will be respected by the medical staff. In the event of a documented advanced directive, implementation will be as specified in medical center policy. This policy memorandum also addresses absence of a documented advanced directive.

2. The Integrated Ethics Consultation team is available for consultation for ethical conflicts regarding the withholding/withdrawal of life sustaining treatment. Any organizational staff member, the patient or family member or legal surrogate may request an Ethics consult.

3. LIPs who for cultural, ethical or religious reasons cannot comply with a patient's wishes will transfer the care of the patient to another qualified LIP who accepts care for the patient. LIPs may opt not to participate in procedures to which they object on an ethical, cultural or religious basis without fear of reprisal or other action, providing care is properly transferred and documented.

INFORMED CONSENT

1. It is the policy of this medical center that patients will be given sufficient information to make an informed decision concerning available treatment options. If the patient agrees, family members or others may be included in the informed consent process. In order to give informed consent, the patient, or the patient’s surrogate decision maker, must understand the nature of the treatment or procedure to be undertaken, the benefits and risks of the treatment, the alternatives to the proposed course of action, and the expected outcome if treatment is declined. This must be explained in language the patient can understand and the patient must be permitted to ask questions which will allow them to make an informed decision freely without coercion or duress. The practitioner must document in a progress note that the treatment or procedure and its indications were discussed with the patient.

2. For the purposes of informed consent, a practitioner is defined as any physician, dentist, or health care professional granted specific clinical privileges to perform the treatment or procedure. The term practitioner also includes: medical and dental residents, regardless of whether they have been granted specific clinical privileges; and other health care professionals whose scope of practice agreement or other formal delineation of job responsibility specifically permits them to obtain informed consent, and who are appropriately trained and authorized to perform the procedure or to provide the treatment for which consent is being obtained.

GENERAL RESPONSIBILITY FOR CARE

1. Conduct of Care

a. All patients, when admitted, as an inpatient to the medical center, shall be assigned to a service or section primarily concerned in the treatment of the disease or medical condition, for which hospitalization was required. Management of the patient's care will be the responsibility of a qualified LIP.

b. All patients, when treated in an ambulatory care setting, shall receive treatment within the defined scope of ambulatory assessment and by a qualified LIP.

c. A uniform level of patient care will be provided by all individuals who are treating patients for the same health problem within and across departments.

d. Patient care coverage is continuous.

e. Continuity of Care is obtained by the coordination of inpatient and outpatient care, and by the communication among LIPs.

2. Emergency Services

a. Emergency services are provided at this medical center. Written policies and procedures guide the provision of that care.

b. The medical center shall accept only those patients for care and treatment who are medically and legally eligible as defined by law and by the Department of Veterans Affairs. For humanitarian reasons, in cases that represent a true medical emergency, medical care will be rendered until such time that the patient's condition is stable enough that he/she can be either transferred to another health care facility or sent home.

3. Admissions

a. Physicians or oral surgeons can be the attending physician for patient admission to inpatient care when privileged to do so. Physician Assistants may be delegated responsibility for admitting patients based on the functional statement/scope of practice.

b. LIPs, when privileged to do so, may order admission to the hospital.

4. History and Physical

a. Inpatient Admissions: On inpatient admission, a medical history is taken and an appropriate physical examination is performed by a qualified LIP. A physician assistant may perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified physician retains accountability for the patient's medical history and physical exam.

(1) All inpatient admissions will be evaluated by a qualified medical staff member within 24 hours of admission.

(2) An H&P examination shall be documented or dictated within 24 hours after inpatient admission of the patient. If an H&P has been performed within 30 days prior to admission, that note may be used with any changes in patient status recorded within the progress note at the time of admission.

(3) Minimal content of an H&P, for a patient admitted to the hospital includes:

(a) History: A history that includes the chief complaint, history of present illness, pertinent past medical history, medications, allergies, and a review of systems (pertinent to patient and situation);

(b) Physical Examination: A physical examination that includes findings pertinent to the patient and situation;

(c) Impression: A concise assessment of the patient's condition; and

(d) Plan: A planned course of treatment

b. Outpatient Procedures Requiring Moderate Sedation: A targeted H&P examination must be completed by a qualified LIP prior to all outpatient procedures performed under moderate sedation. A physician assistant may perform part or all of a patient's medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified physician retains accountability for the patient's medical history and physical exam. The contents of the H&P are targeted to the procedure to be performed, with specific elements outlined in hospital policy. If an H&P has been performed within 30 days prior to the procedure, that note may be used with any changes in the patient status recorded within the progress note at the time of the procedure.

5. Procedures

Medical staff members, LIPs and physician assistants are responsible for communication of the patient's condition to the patient, family, and referring provider, if applicable. They are responsible for securing informed consent as outlined in these bylaws and policy and procedure. They will provide treatment and perform procedures within the scope of approved delineated clinical privileges or scopes of privileges.

6. Tests

Essential diagnostic testing will be ordered in accordance with the policies and procedures outlined in medical center policy available in all clinical units including informed consent if required.

7. Transfers

Interfacility transfers will be in accordance with medical center policy.

8. Consultations

a. The good conduct of medical practice includes the proper and timely use of consultation. It is the duty of the Organized Medical Staff, through its service chiefs, the Chief of Staff and the CEB, to see that those with clinical privileges utilize consultations appropriately.

b. Except in an emergency, consultation is required in the following situations:

(1) When the patient is not a good risk for operation or treatment;

(2) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(3) Where there is significant doubt as to the choice of therapeutic measures to be utilized;

(4) In unusually complicated situations where specific skills of other LIPs may be needed;

(5) When second opinion is requested by the patient or surrogate; and

(6) Psychiatry consultation when any patient who has attempted suicide or who has taken a chemical overdose is admitted to other than the Mental Health & Behavioral Science Service.

9. Service Chiefs will ensure that patient care services are provided in a timely manner and are consistent with patient needs. All consultations will be completed within 72 hours. Clinical departments may implement more restrictive timeframes as necessary.

10. Discharge Planning

Discharge Planning will be initiated as soon as possible after admission and completed in accordance with medical center policy.

11. Discharge

Discharges from the medical center are in accordance with medical center policy.

12. Autopsy

Autopsy will be requested for all deaths and legal authorization by the next of kin for such will be obtained in accordance with medical center policy. Notification of coroner will be in accordance with the state law.

TREATMENT ORDERS

1. General Requirements

a. All orders will be entered electronically into the Computerized Patient Record System (CPRS). Orders that require a handwritten signature (i.e., Schedule II Narcotics, TPN) will be transcribed and signed. Complete orders will be written for each admission and each outpatient visit (if indicated). Under no circumstances will orders from a previous admission or clinic visit be referred to as a substitute for orders written for the current visit or inpatient stay.

b. If an order is to be changed, the original order will be cancelled and a complete new order written.

c. Any orders, including medication, not written by a medical staff member will be written in accordance with the collaborative practice agreement and within the individual's functional statement and scope of practice.

d. Treatment orders are covered in medical center policy.

2. Standing Orders

Standing Orders - No standing medication orders are utilized at this facility.
Protocols and order sets are used at the discretion of each service.

3. Automatic Stop Orders

a. Excluding the exceptions listed in medical center policy, all inpatient medications will be automatically stopped at 28 days after the patient's medication is written. The responsible LIP(s) are notified through electronic alert of pending stop orders prior to expiration.

b. When a patient is transferred to another treatment team or from the critical care unit to a ward, the transferring physician will review and modify all orders as needed. As soon as the patient is transferred, the receiving physician becomes the primary physician and will review and modify all orders as needed.

c. All medications will be reconciled at time of admission and at time of discharge.

4. Verbal Orders

Verbal or telephoned orders that facilitate patient care may be accepted or transcribed on a limited basis. These verbal orders are to be dictated to a registered nurse, pharmacist, or designated qualified allied health professional as defined in medical center policy. All verbal orders require a verification "read back" of the complete order by the person receiving the order to the medical staff member, LIP, or PA who dictated the order. All verbal orders will be signed as defined in medical center policy.

5. Drugs

Drugs used shall meet the standards of the United States Pharmacopoeia with the exception of drugs for bonafide clinical investigation. Use of any investigational drug in this medical center or to treat patients from this medical center recruited into studies must be reviewed and approved by the medical center's Human Studies Subcommittee and Research and Development Committee. Drugs stocked are listed in the medical center formulary.
Exceptions will follow guidelines established in the VHA National Formulary Directive, VISN 9 policies, and local Pharmacy and Therapeutics Committee decisions.

6. Submission of Surgical Specimens

a. All tissue removed shall be sent to Pathology & Laboratory Medicine Service. The pathologists shall make such examinations as are considered necessary to arrive at a diagnosis and reports filed in the medical record. All specimens obtained for laboratory testing shall be sent to Pathology & Laboratory Medicine Service or other specifically designated and approved laboratory (e.g., blood gases, bone marrows, radioimmunoassays).

b. LIPs who plan significant treatment or surgery based on a tissue diagnosis rendered outside the VAMC must first obtain a local pathologist's review and final report on the relevant outside material (slides, tissue blocks, etc.). The purpose is both, to protect the provider (and the VA) from potential miscommunication/error-related liability and to facilitate correlation with the pathological findings in the later removed tissue.

7. Special Treatment Procedures

a. DNAR (Do Not Attempt Resuscitation) orders will be written by physician members of the medical staff. When the attending physician is not readily available, a resident physician may enter the initial order, as outlined in medical center policy.

b. Restraints and Seclusion

(1) Restraints and seclusion will be utilized in accordance with medical center policy.

c. Involuntary Hospitalization: Hospitalization will be consistent with KY State Law and medical center policy.

d. Electroconvulsive Therapy: Electroconvulsive Therapy will be provided by clinically privileged physicians and only after the treatment is agreed upon by two staff psychiatrists, consistent with medical center policy.

ROLE OF ATTENDING STAFF

1. Medical center requirements for supervision of residents are contained in VHA regulations and medical center policy.

MEDICAL RECORDS

1. Basic Administrative Requirements

a. Documentation is to be timely, legible, dated, authenticated. Every effort should be made to minimize the use of the copy and paste function.

b. All staff members are responsible for safeguarding electronic access codes and computer generated medical documents to prevent unauthorized use.

c. In order to meet the requirements of the Joint Commission's National Patient Safety Goals, a listing of abbreviations and symbols that are not to be used in medical record documentation (electronic and hand written) are identified and published.

d. Progress notes are to be documented at least daily on all inpatients.

e. All medical records of discharged patients are to be completed at the time of discharge, or no later than 30 days following the discharge date, after which it is considered delinquent.

2. Release of Information

a. Medical information may be released from the patient's medical record at the patient's request and with the patient's signed authorization or in accordance with VA Privacy Act and HIPPA.

b. All medical records are the property of the medical center and shall not be removed from the premises except by court order or statute in accordance with the Department of Veterans Affairs regulations.

3. Inpatient Medical Record

a. Patient identification (name, SSN/last four, address, DOB, next of kin);

b. History and Physical examination as outlined in medical center policy;

c. Daily progress notes;

d. Operative/Procedure Note;

e. Observations and assessments;

f. Diagnostic and therapeutic procedures, tests and results;

g. Consultation reports;

h. Discharge plan and instructions to patient;

i. Discharge note. Final progress note must describe condition at discharge, i.e. death note, AMA;

j. Informed consent before procedures or treatments undertaken;

k. Autopsy report; and

l. Discharge summary (to include)

(1) The reason for hospitalization;
(2) Significant findings;
(3) Procedures performed
(4) Care, treatment, and services provided;
(5) The patient's condition at discharge; and
(6) Information provided to the patient and family, as appropriate.

4. Outpatient and Emergency Area Medical Records

a. Documentation for each visit to the medical center will be included in the medical record.

b. Notes will contain relevant history of illness or injury and physical findings including vital signs, diagnostic impression, patient disposition, and instructions for follow-up care.

c. The problem list in the medical record will be updated to document significant diagnoses, conditions, and procedures.

d. Records of patients treated in the emergency area will contain time and means of arrival, care received prior to arrival, treatment rendered and results, condition at discharge and follow-up.

5. Delinquent Medical Records

a. The appropriate Service Chief is responsible for ensuring that the medical staff members adhere to the rules. However, sole responsibility for the timely completion and verification of all aspects of the medical record rests with the attending physician. Health Information Management, in conjunction with clinical services, will make appropriate contact

with the physician to ensure completion of medical records in a timely manner, which should not exceed 30 calendar days after the date of discharge. Consistent failure to complete medical records in accordance with these rules may lead to disciplinary action up to and including clinical suspension procedures.

6. Operating Room Records

a. A written pre-anesthesia evaluation will be documented by the anesthesiologist or certified registered nurse anesthetist. A post-anesthesia progress note describing the presence or absence of anesthesia-related complications will be recorded in the record immediately, but no later than 24 hours post op.

b. A pre-operative note describing the patient's condition, pre-op diagnosis, the plan for invasive procedure and informed consent will be documented prior to procedure.

c. Evaluation of postoperative status on admission to and discharge from PACU and documentation requirements for discharge from PACU.

d Reports of Operative and Invasive Procedures: All surgical or invasive procedures performed will be documented by an operative report which is properly authenticated and placed in the medical record as soon as possible after completion of the procedure by an appropriate staff physician. When the operative report is not placed in the medical record immediately, an operative or invasive procedure progress note is entered in the medical record immediately after the operation or procedure to provide other members of the medical staff or other practitioners with sufficient information to provide ongoing and informed care.

e. Operative reports shall be entered or dictated immediately after surgery. Those reports will contain, at a minimum, a description of the findings, the technical procedures used, the specimens removed, the post-operative diagnoses and the name of the primary surgeon and any assistant. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

f. Organs or tissue removed from a living donor or cadaver will be documented in the donor's medical record as an invasive procedure.

INFECTION CONTROL

1. Patients will be placed in isolation in accordance with the Center for Disease Control (CDC) transmission based protocols available on every ward.

2. The CDC guidelines for exposure precautions will be followed.

3. Reportable cases of infectious diseases will be reported (through the VA Infection Control Nurse) to the Health Department as required by state law.

PATIENT SAFETY IMPROVEMENT

1. **Adverse Events** are untoward incidents, therapeutic misadventures, iatrogenic injuries or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient clinic or other VHA facility. Adverse events may result from acts of commission or omission (e.g., administration of the wrong medication, failure to make a timely diagnosis or institute the appropriate therapeutic intervention, adverse reactions or negative outcomes of treatment, etc.).

2. **Sentinel Events** are a type of adverse event. Sentinel events, as defined by The Joint Commission, are unexpected occurrences involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. Major permanent loss of function means sensory, motor, physiologic, or intellectual impairment not previously present that requires continued treatment or life-style change. The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of serious adverse outcomes. Sentinel events signal the need for immediate investigation and response. Some examples of sentinel events include: death resulting from a medication error or other treatment related error; suicide of a patient in a setting where they receive around-the- clock care; surgery on the wrong patient or body part regardless of the magnitude of the operation; and hemolytic transfusion reaction involving the administration of blood or blood products having major blood group incompatibilities.

3. A Close Call/Near Miss is an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention.

4. All close calls, adverse events and sentinel events will be reported to the Patient Safety Program Manager and reviewed as described in medical center policy.

DISASTERS

Assignments for LIPs during mass casualties will contain the assignments to posts, either in the medical center or in mobile casualty stations. It is their responsibility to report to their assigned stations as needed. The Chief of Staff and Medical Center Director will work as a team to coordinate activities and directions. In cases of evacuation from medical center premises, the Chief of Staff, during the disaster, will authorize the movement of patients as directed by the Medical Center Director or his/her designee. The plan for the care of mass casualties as outlined in medical center policy, will be rehearsed at least twice a year by key medical center personnel with thorough critiques for effectiveness.

PROFESSIONAL CONDUCT/COMPETENCE

1. Appropriate professional conduct and competence for all LIPs is expected, including demonstration of behaviors that promote a culture of safety, and is outlined in medical center policy.

2. If there is a reasonable belief or charges of impaired judgment, review actions involving the LIPs may include, but are not limited to urine/blood tests, fitness for duty tests,

and/or offered assistance through the Employee Assistance Program as described in medical center policy.

PROTECTED PEER REVIEW

The organized medical staff shall participate in the Protected Peer Review process as outlined in medical center policy.

Appendix A

ROBLEY REX VAMC MISSION VISION AND VALUES STATEMENTS

MISSION

To honor America's Veterans with exceptional health care that improves their health and well-being.

VISION

- Continue to be recognized as the benchmark of excellence in healthcare by providing exemplary services that are both patient-centered and evidence-based, through education of health care professionals for our veterans, and accelerating discovery and innovation through research; and

- Care will be delivered by engaged, collaborative teams in an integrated environment that promotes learning, research and development, disease prevention, continuous improvement, and provides support in national emergencies.

VALUES

As employees at the LVAMC, we believe there should be certain core values and honorable standards that govern our daily actions and decisions. These five core values are: (1) Integrity; (2) Commitment; (3) Advocacy; (4) Respect; and (5) Excellence. As such, our medical center upholds these values:

- "Integrity" – Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage.

- "Commitment" – work diligently to serve Veterans and other beneficiaries. Be driven by an earnest belief in VA's mission. Fulfill my individual responsibilities and organizational responsibilities.

- "Advocacy" – Be truly Veteran-centric by identifying, fully considering, and appropriately advancing the interests of Veterans and other beneficiaries.

- "Respect" – Treat all those I serve, and with whom I work, with dignity and respect. Show respect to earn it.

- "Excellence" – Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them.

Appendix B

MECHANISM FOR FAIR HEARING AND APPEALS PROCESS FOR REDUCTION AND REVOCATION OF PRIVILEGES

This paragraph defines the policy and procedures related to the reduction and/or revocation of clinical privileges based on deficiencies in professional performance as described below.
Management officials are prohibited from taking or recommending personnel actions (resignation, retirement, reassignment, etc.) in return for an agreement not to initiate procedures to reduce or revoke clinical privileges where such action is indicated.

GENERAL PROVISIONS

1. These activities may be separate from the reappraisal and re-privileging process. Data gathered in conjunction with the facility's performance improvement activity is an important tool for identifying potential deficiencies. Material, which is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process.

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

3. If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures indicated in this directive must be followed. Procedures for reduction and revocation of clinical privileges are identified in paragraphs following, and apply to all LIPs included within the scope of this directive.

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

Note: Summary suspension pending comprehensive review and due process, as outlined in this section on reduction and revocation, is not reportable to the NPDB. However, the notice of summary suspension to the LIP should include a notice that if a final action is taken, it will be reported to the NPDB. The notice of summary suspension should also contain notice to the individual of all due process rights.

5. Procedures Applicable to Administrative Heads. Procedures to reduce and revoke clinical privileges identified within this Appendix are applicable to Directors, COSs, Clinical Managers and VISN Directors. All responsibilities normally assumed by the COS during the clinical privileging reduction or revocation process will be assigned to an appropriate LIP who serves as acting chair of the executive committee of the medical staff. The COS may appeal the Director's decision or the Director may appeal the Associate Director's decision regarding the reduction of privileges decision to the VISN Director just as all LIPs may appeal such a decision. A VISN Director whose clinical privileges to practice at a given facility are reduced or revoked may appeal to the Chief Network Officer.

6. Reduction/Termination of Privileges

(a) Reduction - The applicable service chief will make a recommendation to the Chief of Staff with full documentation of the rationale for the reduction. If the Chief of Staff concurs, he/she notifies the LIP in writing of the intention to reduce clinical privileges.

(b) The notice will include a statement of the right to be represented by counsel and due process rights. A reduction of privileges may include restricting or prohibiting performance of specific procedures, or prescribing and/or dispensing controlled substances.

(c) The LIP will be allowed to review all information not restricted by regulation regarding the proposed changes. The LIP must submit a response within 10 workdays of the Chief of Staff's notice. An extension may be granted by the Chief of Staff, not to exceed 10 workdays.

(d) Reduction of privileges may be time limited and/or have restoration contingent upon a certain condition or time frame. Refer to Medical Staff Bylaws and medical center policy for the official procedure for reduction of privileges. All documentation will be forwarded to the Medical Center Director, who will make a decision on the basis of record.

(e) The LIP may appeal the decision by requesting a hearing within five workdays after receipt of decision. The Medical Center Director will appoint a review panel of three LIPs within five workdays. Two members of the panel must be of the same profession as the involved LIP. The panel will complete its review and submit a recommendation to the Medical Center Director within 15 workdays. The final decision in reduction of privileges review rests with the Medical Center Director, who may accept, reject, partially accept, or modify the panel's recommendation. A reduction of privileges is reportable to the NPDB.

(f) The LIP may submit a written appeal to the Network Director within five workdays of receipt of the Medical Center Director's decision. The Network Director will provide a written decision within twenty workdays. The Network Director's decision is not subject to further appeal.

(g) Revocation - Revocation is the permanent loss of clinical privileges. A revocation of privileges will be made by recommendation of the CEB, based upon review of clinical performance and professional conduct information. When revocation of privileges is proposed and combined with a proposed demotion or dismissal, the due process rights of the LIP will be accommodated by a hearing provided under the dismissal process. Dismissal constitutes a revocation of privileges, and will be reportable to the NPDB. Refer to the Medical Staff Bylaws for the official process involving revocation of privileges.

(1) Revocation for full-time privileged physicians/dentists appointed under 38 USC 7401 will be combined with action to remove the LIP under 38 USC 7464.

(2) Revocation for part-time physicians or privileged consultants/attendings will be combined with action to remove the LIP under VHA Handbook 5005. These appointments may be terminated by the facility to promote efficiency without a termination of the LIP's clinical privileges.

(3) Revocation for clinically privileged LIPs appointed under Title 5 will be combined with action to remove the LIP under the appropriate section of VHA Handbook 5005.

(h) Summary Suspension - The Medical Center Director may, on the Chief of Staff's recommendation, summarily suspend privileges on a temporary basis because of state licensure action or pending the outcome of formal action, when there is sufficient concern regarding patient safety or specific patterns consistent with requirements in VHA policy on credentialing and privileging. The notice of summary suspension will include notice of due process rights of the individual.

(i) Automatic (Administrative) Suspension - The Medical Center Director, on the recommendation of the Chief of Staff, may automatically (administratively) suspend privileges for any provider upon the occurrence of a specific event(s) as noted in Article VI, Section 2, 4. of the Bylaws, that does not require an investigation of clinical care concerns. The Chief of Staff will initiate a timely investigation. If the findings of the investigation support the charges, appropriate disciplinary action will be taken. If findings do not support the charges, the LIP will be returned to full privileges.

MANAGEMENT AUTHORITY

Nothing in these procedures restricts the authority of management to detail or reassign temporarily an LIP to non-patient care areas or activities, thus in effect suspending privileges while the proposed reduction of privileges or discharge, separation, or termination is pending. Further, the facility Director, on the recommendation of the COS, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C. 7405 may be terminated when this is determined to be in the best interests of VA, in accordance with provisions of VA Handbook 5005, without regard to the procedural requirements indicated.

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

VAMC MEMPHIS MEMPHIS, TENNESSEE

SUMMARY OF CHANGES: The VAMC Memphis Medical Staff Bylaws have been updated to be in concert with the Bylaws Template developed by the Office of Quality and Performance (OQP). The changes listed below are based on the VAMC Memphis Bylaws signed January 9, 2009. Please review the following list of changes:

a. Preamble – Added Section 1.01 and 1.02, revised the VAMC Memphis Mission, Vision, and Values statement.

b. Definitions – The following words with definitions were added to the list:

(1) Associate Medical Center Director

(2) Associated Health Professional

(3) Automatic Suspension of Privileges

(4) Community Based Outpatient Clinic

(5) Mid-level Practitioner

(6) Nurse Executive

(7) Outpatient Clinic

(8) Peer Recommendation

(9) Primary Source Verification

(10) Proctoring

(11) Professional Standard Board

(12) Teleconsultation

(13) Telemedicine

c. Article II – Revised Purpose statements 1 through 14 to match the Bylaws template.

d. Article III, Section 3.02 – Added statements Section 3.02, 2 – Clinical Privileges and Scope of Practice and Section 3.02,3 – Change in Status

e. Article III, Section 3.03 – Added this section entitled Code of Conduct

f. Article III, Section 3.04 – Added this section entitled Conflict Resolution

g. Article IV – This article amended to combine previous articles VII Organization of the Medical Staff and IX Clinical Services

h. Article IV, Section 4.01 – Added statements regarding "Other Medical Staff Leaders".

i. Article V and VI – Amended to contain the content of the previous Articles VIII, Committees and Functions and X, Medical Staff Committees.

j. Article V – Descriptive sections regarding the following committees have been added:

(1) Critical Care committee

(2) Compensation Panel

(3) Mental Health Council

(4) Research and Development Committee

(5) Resident Supervision

k. Article VII – contains revisions of the previous Article IV. Additions to Section 7.1 include definitions of Independent Entity, Credentials Review, Deployment/Activation status Employment or Contract and information regarding Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).

l. Article VIII – Revised to describe the processes involved in requesting, granting, renewing, and modifying Clinical Privileges. Article number Revision - previously was Article V.

m. Article IX – New Article – provides discussion of the processes involved in the investigation the behavior, activities, and/or professional conduct of any practitioner with delineated clinical privileges

n. Article X – Article number revision - Previously was Article VI.

o. Article XI – Article number revision – was previously Article XIII

p. Article XIII – Article number Revision – Add additional Medical Staff Rules and Regulations according to medical center policy memorandums.

q. Changed the term "disruptive behavior" to reflect the revision by the Joint Commission to "behavior or behaviors that undermine a culture of safety, which will be effective Spring 2012.

Table of Contents

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the VAMC Memphis in Memphis, TN (hereinafter sometimes referred to as VAMC Memphis, Facility, or Organization) hereby organizes itself for self- governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs (VA), 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.

Section 1.01Main Campus

VAMC Memphis consists of one main campus, which includes a 60-bed Spinal Cord Injury Unit. VAMC Memphis is a tertiary care facility classified as a Clinical Referral Level I Facility. It is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology as well as education and research.

Comprehensive health care is provided through primary, secondary, and tertiary care, in the following areas:

- Medicine
- Surgery (Including Cardiovascular And Neurological Surgery)
- Psychiatry
- Physical Medicine And Rehabilitation
- Spinal Cord Injury
- Neurology
- Oncology
- Dentistry
- Geriatrics
- Ophthalmology
- Optometry

Specialized outpatient services are provided through general, specialty, and subspecialty outpatient clinics including a women's health center. Services are available to more than 196,000 Veterans living in a 53-county tri-state area (Tennessee, Arkansas, and Mississippi).

Section 1.02Community Based Outpatient Clinics (CBOC)

There are ten community based outpatient clinics in the VAMC Memphis catchment area. Three of these are VA staffed - the VAMC Memphis South CBOC is located 6.5 miles from the medical center, with more than 10,000 Veterans receiving primary care and mental health services at this clinic location; the VAMC Memphis North CBOC, located 11.5 miles from the medical center also provides primary care and mental health services to more than 7,700 patients; the VAMC Memphis Jackson, TN CBOC located 80 miles from the medical center, more than 2000 Veterans are receiving care at this facility. The remaining seven are contract Community Based Outpatient Clinics (CBOC) located in:

- Smithville, Mississippi
- Byhalia, Mississippi
- Jonesboro, Arkansas
- Savannah, Tennessee
- Dyersburg, Tennessee
- Bolivar, Tennessee
- Helena, Arkansas

These contract clinics provide primary care, and reduce the travel distance for approximately 5,000 Veterans in outlying counties. In all, Memphis provides some 402,170 outpatient visits annually.

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

MISSION, VISION & VALUES

Mission

To honor America's Veterans in all that we do by providing timely, quality care; outstanding customer service; education of tomorrow's health care providers, and improvement in health care outcomes through research.

Vision

To be a patient-centered health care organization for Veterans providing excellent health care, education and research; an organization where people choose to work; and an active community partner.

Key Business Drivers

- Quality
- Financial Integrity
- Patient Satisfaction
- Employee Satisfaction

VA Core Values and Characteristics

Because **I CARE**, I will…

Integrity	Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage.
Commitment	Work diligently to serve Veterans and other beneficiaries. Be driven by an earnest belief in VA's mission. Fulfill my individual responsibilities and organizational responsibilities.
Advocacy	Be truly Veteran-centric by identifying, fully considering, and appropriately advancing the interests of Veterans and other beneficiaries.
Respect	Treat all those I serve and with whom I work with dignity and respect. Show respect to earn it.
Excellence	Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them.

VA CORE CHARACTERISTICS

Trustworthy	VA earns the trust of those it serves – every day – through the actions of all employees. They provide care, benefits, and services with compassion, dependability, effectiveness, and transparency.
Accessible	VA engages and welcomes Veterans and other beneficiaries, facilitating their use of the entire array of its services. Each interaction will be positive and productive.
Quality	VA provides the highest standard of care and services to Veterans and beneficiaries while managing the cost of its programs and being efficient stewards of all resources entrusted to it by the American people. VA is a model of unrivalled excellence due to employees who are empowered, trusted by their leaders, and respected for their competence and dedication.
Innovative	VA prizes curiosity and initiative, encourages creative contributions from all employees, seeks continuous improvement, and adapts to remain at the forefront in knowledge, proficiency, and capability to deliver the highest standard of care and services to all of the people it serves.
Agile	VA anticipates and adapts quickly to current challenges and new requirements by continuously assessing the environment in which it operates and devising solutions to better serve Veterans, other beneficiaries, and Service members.
Integrated	VA links care and services across the Department; other federal, state, and local agencies; partners; and Veterans Services Organizations to provide useful and understandable programs to Veterans and other beneficiaries. VA's relationship with the Department of Defense is unique, and VA will nurture it for the benefit of Veterans and Service members.

DEFINITIONS

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

A. Allied Health Practitioner: Non-physician dependent practitioners who are qualified to render direct or indirect care under the supervision or direction of a medical staff member and have been approved by the medical staff to work under a scope of practice. (Also referred to as Associated Health Professional.)

B. 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 VAMC Memphis. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.

C. Associate Medical Center Director: The Associate Medical Center Director fulfills the responsibilities of the Medical Center Director as defined in these bylaws when serving in the capacity of Acting VAMC Memphis Medical Center Director.

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

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

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

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

H. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the VAMC Memphis Medical Center Director. The Medical Center 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.

I. Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the VAMC Memphis 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 and others with doctoral degrees that are permitted by law

to function independently. It may also include individuals who can practice independently, who meet this criterion for independent practice.

J. Medical Center Director: The Medical Center Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the VAMC Memphis. The Medical Center Director (MCD) is assisted by the Chief of Staff (COS), the Associate Medical Center Director (AMCD), the Associate Medical Center Director for Patient Care Services (AMCD-PCS), the Assistant Medical Center Director and the CEB.

K. Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the medical staff process that are subject to the medical staff bylaws. This includes the ***Active Medical Staff***, the ***Consulting and Attending Staff,*** and the ***House staff***.

L. Mid-Level Practitioner: Mid-Level Practitioners are those health care professionals who are not physicians and dentists and who, most often, function within a Scope of Practice but may practice independently on defined clinical privileges as defined in these Bylaws. Mid-Level Practitioners include: physician assistants (PA), and advanced practice nurses (ARNP, CRNA, and CRNP). Mid-Level Practitioners 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 Practitioner when required. Mid-Level Practitioners 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.

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

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

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

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

Q. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required

reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.

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

S. Rules: Refers to the specific rules set forth that govern the Medical Staff of the VAMC Memphis. 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 CEB and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Medical Center Director.

T. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider.

U. 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.

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

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, VAMC Memphis.

ARTICLE II. PURPOSE

The purposes of the Medical Staff shall be to:

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

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

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

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

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

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

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

H. Provide a medical perspective, as appropriate, to issues being considered by the Medical Center Director and Governing Body.

I. 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.

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

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

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

M. 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.

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

O. Abide by, review, and revise these Bylaws.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 3.01Eligibility for Membership on the Medical Staff

A. **Membership:** Membership on the Medical Staff is a privilege extended to all professionally competent physicians, dentists, and others with doctoral degrees who are permitted by law to function independently and who continuously meet qualifications, standards, and requirements of VHA, this VA Medical Center, and these Bylaws.

B. **Categories of the Medical Staff:**

1. **Active Medical Staff:** consisting of physicians, dentists, and others with doctoral degrees who are permitted by law to function independently and who are directly and independently responsible for specific aspects of patient care, education or research activities of the Medical Center and who assume all the functions and responsibilities of membership on the Medical Staff. Members of the Active Medical Staff shall serve, when called upon, as members of Medical Staff and Medical Center committees with full voting rights, and shall satisfy the requirements stated in these Bylaws concerning attendance at meetings of the Medical Staff, of departments and of committees to which the member is assigned.

2. **Consulting and Attending Medical Staff:** consisting of practitioners who are responsible for supplementing the members of the Active Medical Staff in their roles in patient care, education and research, who are responsible for adhering to these Bylaws, except as specifically noted. Members are appointed to a specific service and shall be permitted to serve on committees. They are encouraged but not required to attend general meetings of the Medical Staff, shall not have voting privileges except on committees to which they are specifically appointed, and shall not hold offices or administrative positions in services to which they are assigned.

3. **House staff**, consisting of medical and dental interns, residents and other trainees engaged in approved courses of training and education at this Medical Center, with or without compensation. They are expected to perform in a manner consistent with these Bylaws.

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

5. No practitioner is automatically entitled to membership on the Medical Staff or to exercise particular clinical privileges solely because of license to practice in this or in any other state, because of membership in or employment by any other professional organization, because of certification by any clinical board, or because of past or current Medical Staff membership or privileges held at another healthcare facility or in another practice setting.

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

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

1. Active, current, full and unrestricted *license to pr*actice 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.

2. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine, Osteopathy, Dentistry or other doctoral degrees in fields permitting independent practice from an approved college or university;

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

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

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

6. 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 VAMC Memphis has a patient care need, and adequate facilities, support services and staff

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

8. English language proficiency.

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

10. 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).

11. United States citizenship, unless it is not possible to recruit qualified citizens. Practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment, with proof of current appropriate visa status and documentation from Immigration and Naturalization Service of employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Manual MP-5, Part II, Chapter 2;

B. **Clinical Privileges and Scope of Practice:** While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent

Practitioners are permitted by this VAMC Memphis and these Bylaws to practice independently. All Practitioners listed below are subject to the bylaws whether they are granted defined clinical privileges or not

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

   (a) Physicians

   (b) Dentists

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

   (a) Psychologists

   (b) Podiatrists

   (c) Optometrists

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

   (a) Physician Assistants.

   (b) Advanced Practice Nurses

   (c) Certified Registered Nurse Anesthetists

   (d) Clinical Social Workers

   (e) Doctors of Pharmacy

   (f) Clinical Pharmacy Specialist

   (g) Audiologists

   (h) Speech Pathologists

   (i) Clinical Dieticians

   (j) Social Workers

   (k) Neurology – Sleep Study Technicians

   (l) Physical Therapists (Occupational, Vocational, Kinesiology, Physical)

C. **Change in Status:** Members of the Medical Staff as well as all Practitioners practicing through privileges or a scope of practice must agree to provide care to patients within the scope of their Delineated Clinical Privileges or Scope of Practice and advise the Medical Center Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges which are held, and any changes in the status of professional credentials,

such as, but not limited to, loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society as soon as able, but no longer than 15 days after notification of the practitioner.

Section 3.03 Code of Conduct

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

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

1. Behaviors that undermine a culture of safety are 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 behaviors that

undermine a culture of safety are 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, behaviors that undermine a culture of safety may reach a threshold that constitutes grounds for further inquiry by the CEB into the potential underlying causes of such behavior. Behaviors that undermine a culture of safety by a provider could be grounds for disciplinary action.

2. VAMC Memphis distinguishes behaviors that undermine a culture of safety from constructive criticism that is offered in a professional manner with the aim of improving patient care. VAMC Memphis also reminds its providers of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a provider's health and performance. Providers suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

3. Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing behaviors that undermine a culture of safety on the part of other providers. VAMC Memphis urges its providers to support their hospital, practice, or other healthcare organization in their efforts to identify and manage behaviors that undermine a culture of safety, by taking a role in this process when appropriate.

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

Section 3.04 Conflict Resolution & Management

For VAMC Memphis 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 the 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. VAMC Memphis policy memorandum 00-02 MEDIATION PROGRAM and the VA Handbook 5978.1, *Alternative Dispute Resolution Program*, address the conflict resolution and management processes available locally and in VA-wide, respectively, 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. VAMC Memphis 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

A. Composition: The Chief of Staff, Associate Chief of Staff for Ambulatory Care, Associate Chief of Staff for Research and the Associate Chief of Staff for Education.

B. Qualifications:

1. Chief of Staff: The incumbent must be a board certified physician with advanced clinical experience as well as demonstrated administrative and leadership skills; demonstrates commitment to an interdisciplinary approach to care delivery; has documented ability to coordinate a broad continuum of programs; has management experience with strong administrative and interpersonal skills, and demonstrates skills in providing clinical interface with academic affiliates and other key stakeholders.

2. Associate Chief of Staff for Ambulatory Care: The incumbent must be a board certified physician in internal medicine with advanced clinical experience as well as demonstrated administrative and leadership skills. The incumbent must be eligible to be clinically privileged in a medicine discipline with leadership acumen sufficient to provide direction for single and complex programs in the delivery of ambulatory care services

3. Associate Chief of Staff for Research: The incumbent must be a board certified physician in a health care specialty that provides opportunity for advanced clinical experience as well as demonstrated administrative and leadership skills. The incumbent must have research experience and knowledge of merit review programs, such as Association for Accreditation of Human Research Protection Programs (AAHRPP), etc. The incumbent must be eligible to be clinically privileged in a health care discipline. The incumbent must meet the requirement for an academic appointment at the University of Tennessee and must have leadership acumen sufficient to provide direction for single and complex programs in the delivery of research services to inpatients and outpatients;

4. Associate Chief of Staff for Education: The incumbent must be a board certified physician in a health care specialty that provides opportunity for advanced clinical experience as well as demonstrated administrative and leadership skills. The incumbent must have a strong experience in oversight of education programs. The incumbent must be eligible to be clinically privileged in an internal medicine specialty. The incumbent must meet the requirement for an academic appointment at the University of Tennessee, and must have leadership acumen sufficient to provide direction for single and complex programs in the delivery of Education Services to employees and housestaff.

C. Selection and Removal: The Medical Staff has no elected officers. VHA has no requirement or mechanism for appointment or election of “officers” of the Medical Staff.

D. Duties:

1. Chief of Staff is appointed and has oversight responsibilities of the Medical Staff and serves as Chairperson of the CEB. The Chief of Staff (COS) provides administrative, programmatic, and clinical leadership for the VAMC Memphis clinical, medical, and dental staff to ensure achievement of the clinical, research, and education

goals of the medical center. The COS is accountable for the management of the needs of the clinical services, as well as developing a plan for the delivery of health care by the clinical staff. The COS, as a member of the executive leadership team for the VAMC Memphis participates in top-level decision and policy design that affects the needs of the medical center through collaboration with other members of the medical center administration, service chiefs, and interdepartmental supervisors. The COS directs the clinical medical programs, delegating authority and responsibility to meet the medical center goals. The incumbent reports to the Medical Center Director and serves as a key clinical resource for the Medical Center Director and other members of the administration.

2. **Associate Chief of Staff for Ambulatory Care (ACOS, AMB. Care):** The Associate Chief of Staff for Ambulatory Care (ACOS/Amb. Care) provides administrative, clinical, and programmatic leadership for the ambulatory care programs to ensure achievement of the clinical, research, and education goals and applicable performance measures. The ACOS/Amb. Care is accountable for the delivery of all medical care by the staff of the Amb. Care. The incumbent serves as an extension of the Chief of Staff and the position is one that is identified as primary back up for the Chief of Staff. Because of this, the incumbent is expected to maintain awareness of the broad functions of the medical center and medical center specific performance measures sufficient to actively support the Chief of Staff.

3. **The ACOS, Research Service** provides administrative, clinical, and programmatic leadership for the Research Service to ensure achievement of the clinical, research, and education goals and applicable performance measures. The incumbent serves as an extension of the Chief of Staff and the position is one that is identified as primary back up for the Chief of Staff. Because of this, the incumbent is expected to maintain awareness of the broad functions of the medical center and medical center specific performance measures sufficient to support actively the Chief of Staff.

4. **Associate Chief of Staff, Education Service (ACOS/E):** The ACOS/E provides administrative, clinical, and programmatic leadership for the Education Service to ensure achievement of the clinical, research, and education goals and applicable performance measures. The ACOS/E serves as the Chief Academic Affiliations Officer for the Memphis VA and functions as the liaison to the officials of the University of Tennessee, VA Office of Academic Affiliations, and senior management and clinical service chiefs of the VA. The incumbent serves as an extension of the Chief of Staff and the position is one that is identified as primary back up for the Chief of Staff. Because of this, the incumbent is expected to maintain awareness of the broad functions of the medical center and medical center specific performance measures sufficient to actively support the Chief of Staff.

Section 4.02 Leadership

The Medical Staff, through its committees and Service Chiefs, provides counsel and assistance to the Chief of Staff and the Medical Center 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

A. **Characteristics**:

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

2. Clinical Services hold service-level meetings no less than ten times per year.

B. Functions:

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

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

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

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

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

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

7. On-call schedules will be maintained by all clinical services, to assure that all patients have an appropriate practitioner immediately available to attend them for any emergency that may occur.

8. Annually review privilege templates for each Service and make recommendations to the CEB.

C. **Selection and Appointment of Service Chiefs:** Service Chiefs are appointed by the Medical Center Director based upon the recommendation of the Chief of Staff. Separate from these Bylaws, and in compliance with VA/VHA Policy, the VAMC Memphis determines how the 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 of each applicant. Criteria for appointment as Service Chief include Board Certification/or equivalent experience and comparable training as vetted through the credentialing process.

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

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

2. Clinically related activities of the Service.

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

4. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges through Focused Professional Practice Evaluation (FPPE) / Ongoing Professional Practice Evaluation (OPPE).

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

6. Appropriately, recommending clinical privileges or scope of practice for each member of the Service.

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

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

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

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

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

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

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

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

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

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

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

18. Participating as part of the senior management team of the medical center.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

A. Committees are either standing or special.

B. 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.

C. The presence of 51% of a committee's members will constitute a quorum.

D. The members of all standing clinical committees, other than the CEB (CEB) are appointed by the Chief of Staff subject to approval by the CEB, unless otherwise stated in these Bylaws.

E. Unless otherwise set forth in these Bylaws, the Chair of each subcommittee of the CEB is appointed by the Chief of Staff.

F. Robert's Rules of Order will govern all committee meetings.

Section 5.02 Executive Committee of the Medical Staff

The Clinical Executive Board (CEB) serves as the Executive Committee of the Medical Staff.

A. **Characteristics:** The members of the CEB are:

1. Chief of Staff, Chairperson, voting.
2. Clinical Service Chiefs, voting.
3. Chairpersons of the subcommittees of the CEB, voting.
4. Medical Staff Member at large, voting.
5. Medical Center Director, or designee, ex-officio, non-voting.
6. Associate Medical center Director, Patient Care Services, Nurse Executive, ex- officio, voting.

7. Other VAMC Memphis 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.

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

B. Functions of the CEB:

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

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

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

4. Makes recommendations directly to the Medical Center Director regarding the:

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

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

(c) Delineation of privileges for each Practitioner credentialed.

(d) Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and other relevant external standards.

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

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

(g) Oversees process for fair-hearing procedures consistent with approved VA mechanisms.

(h) Monitors medical staff ethics and self-governance actions.

(i) Advises VAMC Memphis leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.

(j) Receives and acts on reports and recommendations from medical staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Executive Management Board.

(k) 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 VAMC Memphis policies and procedures.

(l) Acts upon recommendations from the Credentialing and Privileges Committee.

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

(n) Provides oversight and guidance for fee basis/contractual services.

(o) Annually reviews and makes recommendations for approval of the Service- specific privilege lists.

C. **Meetings:**

1. Regular Meetings: Regular meetings of the CEB shall be held no less than ten times per year. The Chairmen of the various subcommittees of the Medical Staff shall report the activities and recommendations of their committees at regular meetings of the CEB.

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

3. Meeting Notice: All CEB members shall be provided at least 1 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 CEB. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to board meetings.

E. **Quorum:** A quorum for the conduct of business at any regular or emergency meeting of the CEB shall be a majority of the voting members of the board (or 51% of the membership), unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

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

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

H. **Information Flow to CEB:** All Clinical Executive Board subcommittees, including but not limited to those listed below, will submit minutes of all meetings to the CEB in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the CEB.

Section 5.03 Committees of the Medical Staff

The following Standing Committees are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Mid-Level and Allied Health Practitioners, (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners, and (g) for such additional purposes as may be set forth in the charges to each committee:

A. **CLINICAL PRACTICES GROUP (CPG)** –

1. Charge: The CPG serves as the advisory work group to the CEB.

2. Composition: The membership of the CPG shall be the Chief of Staff, Associate Chiefs of Staff, and all Clinical Service Chiefs. The Chief of Staff shall serve as the chair. This work group will provide a framework to link quality improvement activities, foster identification, and resolution of problems.

3. Meetings: The group meets at least ten times per year and at the call of the COS.

B. **BLOOD AND BLOOD PRODUCTS USAGE COMMITTEE:** The Blood Usage Committee is involved in the development and maintenance of surveillance over blood and blood component transfusion practices and procedures.

1. Charge: The committee ensures that current policies cover the use of blood and blood components are readily available and periodically reviews and revises said policies and procedures. The committee reviews medical records, transfusion documentation, transfusion reaction information, reviews the incidence of any infection from blood and blood products and sets the standards for obtaining blood products.

2. Composition: The membership of the Blood Usage Committee is as follows: Pathology and Laboratory Service, Blood Bank, Medical Director (Chairperson), Anesthesia Service Representative, Staff Anesthesiologist, Pathology and Laboratory Service, Blood Bank, Supervisor, Pathology and Laboratory Service, Quality Control and Ancillary Testing Coordinator, Medical Service, Representative, Ambulatory Care Service, Representative, Emergency Room/Triage, Nursing Service, Representative,

Nursing Service Representative, Nursing Education, Surgical Service, Representative QM & I, QA/UR Specialist, Chief of Staff Office Representative, Project Manager.

3. Meetings: This committee meets quarterly.

C. CARDIOPULMONARY RESUSCITATION (CPR) COMMITTEE:

1. Charge: Have the responsibility for the assessment, planning, implementation, and evaluation of the effectiveness of resuscitation efforts, including all emergency equipment, medications, and supplies for code carts, and advanced airway carts; review and approve requests for changes in equipment, medications, or supplies; review all Blue Alert forms and "Quality Improvement Review of Code" forms. Be responsible for relaying documented equipment deficiencies, problems, or user errors to Quality Management and Performance Improvement (Patient Safety/Risk Manager) and others as needed for action; access BLS/ACLS training documentation available through Education Service monthly to ensure compliance with medical center policy.
(Reference Policy 11-51 Cardiopulmonary Resuscitation (Blue Alert) Policy)

2. Composition: Medical Service, Pulmonary Section Representative , Medical Service, Respiratory Section Representative, Medical Service, Representative - Staff Physician, MICU, Pharmacy Service, Clinical Pharmacists, Nursing Service, Chief, SPD, Nursing Service, Representative, Nurse Manager, MICU/CCU, Nursing Service Representative, Nursing Education, Surgical Service, Representative, Office of Information and Technology Representative, Risk Manager, QM&I, Chief of Staff Office Representative, Project Manager

3. Meetings: Monthly, no less than ten times per year.

D. CANCER COMMITTEE:

1. Charge: To provide guidance to the comprehensive cancer center, this includes clinical treatment programs and a clinical research program. The committee will promote a coordinated interdisciplinary approach to patient management at all levels. The committee is responsible for planning; initiating stimulating, and assessing consultative services to patients, making certain that educational programs include major cancer sites, evaluating the quality of care for those patients with cancer and to supervise the cancer data system.

2. Composition: The membership of the Cancer Committee is as follows: Hematology-Oncology Section Chief, Radiation Oncology Service Chief, Pathology and Laboratory Service Chief, Radiology Service Chief, Cancer Liaison Physician, Nursing Service Representative - Nurse Manager, Hematology-Oncology Section, Social Work Service Representative Social Worker – Hematology-Oncology Section, Tumor Registry Coordinator, QM&I Representative – Risk Manager, Chief of Staff Office Representative.

3. Meetings: At a minimum of six times per year.

E. **CLINICAL PRIVILEGES COMMITTEE (CPC):** The CPC shall review the credentials of all independent practitioners and recommend to the CEB and the Medical Center Medical Center Director that the appropriate clinical privileges are granted. (Reference Policy Memorandum #11-21)

1. Charge: Review applications for appointment to the Medical Staff referred to it by the Chief of Staff or his designee(s); review the recommendations of the Chief of Staff and Service Chiefs; conduct personal interviews of candidates at its discretion; conduct a personal interview with the Chief of Staff and/or Service Chief in all instances of disapproval of an application by the Chief of Staff and/or Service Chief or both. In the event of the intent of the Committee to recommend disapproval, personal interviews shall be held with the Chief of Staff and Service Chief, if appropriate and with the candidate after written notification to the candidate of the intended disapproval. Between re-credentialing cycles, review the status and appropriateness of clinical privileges when cases are referred by the Chief of Staff or Service Chief. At the request of the Chief of Staff, review new/proposed changes to delineation of clinical privileges form(s); recommend appropriate action to the Professional Standards Board or CEB.

2. Composition: Associate Chief of Staff Ambulatory Care; Chief Mental Health Service; Chief, Spinal Cord Injury Service: Chief, Radiology Service: Chief, Medical Service; Associate Medical Center Director, Patient Care Services; Chief, Surgical Service: Chief, Radiology Service; Chief, Dental Service: Medical Staff Coordinators (ex-officio).

3. Meetings: Monthly, no less than ten times per year.

F. **CRITICAL CARE COMMITTEE:**

1. Charge: The Critical Care Committee will be responsible for developing policies and procedures that improve the care of patients in the ICU's and enhance the efficiency of service in the ICU's. The Critical Care Committee will be chaired by the Medical Director, MICU/CICU. The Critical Care Committee is a subcommittee of the CEB.

2. Composition: Chairperson, Director, Medical ICU; Medical Service, Chief; Medical Director, Coronary Care Unit; Medical Director, Surgical ICU; Medical Director, Respiratory Therapy; Chairperson, CPR Committee; Medical Service, Staff Physician, MICU; Medical Service, Cardiology Section Representative; Surgical Service, Representative; Surgical Service Resident & Critical Care Fellow; Chief, Acute Surgery; Nursing Service, Nurse Manager - MICU/CICU; Nursing Service, Nurse Manager – SICU; Nursing Service, Education Representative; Infection Control Nurses; Pharmacy Service, Representatives;; Project Manager/ Chief of Staff Office; Quality Management, Risk Manager; Respiratory Therapy Section Supervisor.

3. Meetings: Monthly, no less than ten times per year.

G. **COMPENSATION PANEL:**

1. Charge: The Compensation Panel recommends to the Medical Center Director the appropriate pay table, tier level and market pay amount for individual physicians and dentists. The Compensation Panel will meet at the call of the COS. The Compensation Panel's recommendations with regard to pay for individual physicians or dentists will take into consideration board certification, experience, unique contributions, role in teaching, research grants, committee responsibilities and all other pertinent information to arrive at the amounts recommended. (VA Handbook 5007/21, Part IX)

2. Composition: Each panel is comprised of at least three physician or dentist members, as applicable, one of which is designated as chairperson. At least one physician or dentist will hold a management position; and at least two physicians or dentists who are practicing clinicians and who do not hold management positions at the VAMC Memphis .Physician panels will be comprised solely of physicians. Dentists' panels [at tier 1] will have at least two dentists. Panel members must be in a tier equal to or higher than the tier for which the physician or dentist is being considered. Physicians and dentists may not be members of the convened panel that makes recommendations regarding their own pay. (VA Handbook 5007/21, Part IX)

3. Meetings: At the call of the Chief of Staff.

H. DEMENTIA COMMITTEE:

1. Charge: The Dementia Committee is a multidisciplinary hospital-wide committee. Its purpose is to improve dementia care across all care venues for the VAMC Memphis. The Dementia Committee will monitor and evaluate the effectiveness of the care provided to Veterans with a diagnosis of dementia. The committee will be responsible for developing and making recommendations for program and infrastructure to meet the overall focus of local dementia health care needs.

2. Composition: The membership of the Dementia Committee is as follows: Chairman: Mark Brint, MD; Gail Berntson, MD HBPC, William Nathan Rawls, PharmD, Jennifer Jacobson, Clinical Psychologist, Emily Connell, Social Worker

3. Meetings: Monthly, no less than ten times per year.

I. ETHICS CONSULTATION COMMITTEE:

1. Charge: The Ethics Consultation Committee is a multidisciplinary hospital-wide committee. Its purpose is to assist patients, family members, medical providers, employees and other parties to resolve medical ethics issues and appropriate medical concerns

2. Composition: The membership of the Ethics Consultation Committee is as follows: Chief, Social Work, Chaplain Service Representative, Nursing Service Chief or designee, Pharmacy Service Chief or designee, Spinal Cord Injury, Chief or designee, Anesthesia Service Chief or designee, Nursing Service – Nurse Representative, Staff Physician – Medical Service, Staff Physician, Mental Health Service, and Chief of Staff Office Representative

3. Meetings: Monthly, no less than ten times per year.

J. HEALTH PROMOTION DISEASE PREVENTION PROGRAM COMMITTEE (HPDPPC):

1. Charge: The HPDPPC will ensure the integration of health promotion and disease prevention services into clinical care delivery within the medical center and affiliated community based outpatient clinics (CBOC's). The committee will assess patient and programmatic needs, identify internal and community resources, and develop, implement, coordinate and evaluate evidence based HPDP programming that addresses the following core prevention messages:

   a. Get Involved in Your Health Care
   b. Be Safe
   c. Be Tobacco Free
   d. Be Physically Active
   e. Eat Wisely
   f. Strive for a Healthy Weight
   g. Manage Stress
   h. Limit Alcohol

2. Composition: The membership of the HPDPPC; Health Behavior Coordinator (HBC Co-Chair); MOVE! Coordinator; Smoking and Tobacco Use Cessation Lead Clinician; Veterans Health Education Coordinator; My Health*e*Vet Coordinator; Representative from Primary Care; Representative from each affiliated CBOC; Primary Care-Mental Health Integration (PC-MHI) representative; and a Specialty Care Representative.

3. Meetings: Monthly, no less than ten times per year.

K. INFECTION CONTROL COMMITTEE:

1. Charge: Define, survey, correlate, review, evaluate, revise and institute whatever recommendations are necessary in order to prevent, contain, investigate and control hospital acquired infections and other infectious diseases among patients and personnel; submit committee minutes to the CEB ; and report a summary of its activities to the CEB annually. See Policy Memorandum #11-39 Infection Control and Infection Control Committee.

2. Composition: Hospital Epidemiologist; Nursing Service Representative; Medical Service; Representative; Surgical Service Representative; Dental Service Representative; Pathology and Laboratory Medicine Service Representative; Pharmacy Service Representative; Mental Health Service Representative; Nutrition and Food Service Representative; Occupational Health Representative; Infection Control Nurses; Chief, SPD; Industrial Hygienist; Chief, Environmental Management Section; Administrative Assistant to the Chief of Staff; Assistant Chief or Supervisor, EMS

3. Meetings: Monthly, no less than ten times per year.

L. **LABORATORY UTILIZATION COMMITTEE:**

1. Charge: The Laboratory Utilization Committee monitors delivery of laboratory services in the medical center and makes recommendations to management on policies concerning laboratory services. Utilization reviews allow evaluations of all aspects of laboratory testing including appropriateness of test ordering, adequate specimen collection, appropriate test menu and timeliness of reporting test results. Other ongoing tasks include (1) Improving communication between services involved with provision of or use of clinical laboratory services, and (2) Education on the use of laboratory tests for screening, diagnosis, and patient follow-up. The committee will meet at least six times per year and at the call of the chairperson.

2. Composition: Members are Medical Service Representative (Chairperson), Path and Lab. Director of Clinical Pathology, Path and Lab. Ancillary Testing & Quality Assurance Coordinator, Ambulatory Care Service Representative – North Clinic, Ambulatory Care Service Representative – South Clinic, Ambulatory Care Service Representative – ER/Triage, Clinical Application Coordinator Representative, Surgical Service Representative, Nursing Service Representative, ANE, Ambulatory Care, Nursing Service Representative, Nurse Manager, Emergency Room & Triage, Nursing Service Representative, Nurse Manager, Health Technicians, Nursing Service Representative, Hematology/Oncology & Dialysis, Pharmacy Service Representative, Quality Management and Improvement Representative, Chief of Staff Office Representative, Project Manager, and Medical Service – Chief Resident (ex-officio)

3. Meetings: This committee meets quarterly

M. **MEDICATION USE COMMITTEE:**

1. 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 VAMC Memphis for complete current information on matters related to pharmaceuticals and current pharmaceutical practices.

2. Composition: Members of Medical, Nursing, Pharmacy, and Administrative Staffs: One Physician member and one Pharmacist member serve as co-chairpersons, Three members of the committee are senior members of the medical staff, three are members of the clinical pharmacy staff; one member represents Nursing Service, one member is the Hospital Risk manager and one member is the Chief of Staff representative – Administrative Assistant to the COS.

3. Meetings: Monthly, no less than ten times per year.

N. **MENTAL HEALTH COUNCIL:**

1. Charge: The Mental Health Council is to provide for the needs of the mental health patients and staff throughout the medical center by fostering an interdisciplinary team approach to the treatment of mental health patients and management of resources allocated for this purpose. The overall goal is to provide an interdisciplinary structure that ensures patients are provided all the needed services in the most cost effective and efficient manner.

2. Composition: Members of the Mental Health Council are as follows: Ambulatory Care Service Representative, Associate Director for Patient Care, Nurse Executive, Chief Business Office or designee, Chief Chaplain Service or designee, Chief Human Resource Management Service or designee, Chief Mental Health Service, Section Chief Chemical Dependency Center, Outpatient Clinic Representative, Coordinator, Admission Intervention Team, Coordinator, Post-Traumatic Stress Disorder Clinical Team, Coordinator, Psychosocial Rehab & Recovery Center, Administrative Officer Mental Health Service, Chief Nurse, Mental Health Service, Nutrition and Food Service Representative, Physical Medicine and Rehabilitation Service Representative, Chief Psychology Section, Chief, Social Work Service, Mental Health Supervisor, Utilization Review Coordinator, QM&I Representative, Team Leader Vet Center, Administrative Assistant to the Chief of Staff. The Chairperson of this Council is rotated every 6 months among the Management Level members that represent the disciplines of the service: Psychiatry, Psychology, Social Work, and Nursing.

3. Meetings: Monthly, no less than ten times per year.

O. **NUTRITION COMMITTEE:**

1. Charge: The Nutrition Committee is an interdisciplinary group whose purpose is to assist the primary physician in the treatment of patients at nutritional risk with the least amount of morbidity and mortality related to these processes. The recommendations of this committee will be submitted to the CEB for action and implementation.

2. Composition: Chief, Clinical Section (Nutrition and Food Service) (Co- Chairperson), Pharmacy Service – Clinical Pharmacy Specialist (Co-Chairperson), Ambulatory Care Service Representative, Dental Service Representative, Medical Service – Gastroenterology Section Representative, Medical Staff Representative, Physician, Nursing Service, Registered Nurse, Nutrition and Food Service, Clinical Staff Dietitian, Nutrition and Food Service, Registered Clinical Dietitian, Pharmacy Service, Pharmacist, PM & R Service – Dysphasia Specialist, Quality Management and Improvement Representative, Social Work Service Representative, Spinal Cord Injury Service Representative, Surgical Service - Otolaryngology Section Representative, Surgical Service Representative.

3. Meetings: This committee meets quarterly.

P. **PHYSICAL STANDARD BOARD:**

1. Charge: The Physical Standards Board is responsible for determining the physical fitness of employees to continue to work in their present positions and for recommending action based upon examination of findings. Only those cases of questionable nature, which have not been resolved, or have been resolved unfavorably by consultation, will be referred to the Physical Standards Board for determination of physical fitness. Referrals to be made by Human Resources Management Service to the Chief of Staff. The Board will render its opinion as to whether or not the individuals employee examined can perform the required service satisfactorily without hazard to patients, employees or self. See Policy Memorandum # 11-13 – Physical Standards Board.

2. Composition: Members of the Physical Standards Board will be named to provide the needed expertise for an appropriate medical opinion.

3. Meetings: This Board meets as needed.

Q. **PROFESSIONAL STANDARDS BOARD:**

1. Charge: The Professional Standards Board (PSB) acts to make recommendations to the Medical Center Director. The Physicians/Dentist Professional Standard Board's primary functions are to: a. Review and act on employment applications and determine whether the applicant meets the requirements set forth in VA qualification standards. [Sound professional and administrative judgment will be exercised in reviewing applications to ensure that VA obtains the best qualified personnel]; b. Review completely an individual's qualifications for advancement by an examination of the personnel folder, proficiency reports or performance appraisals, supervisory evaluations, and other pertinent records; and to make recommendations based on their findings; c. Conduct probationary reviews for individuals appointed under 38 U.S.C. 7401(1) and d. Execute VA Form 10-2543, Board Action. The PSB also acts to make recommendations for promotions and special advancements for non- physician providers. .

2. Composition: The membership of the Professional Standards Board is as follows: Chief of Staff, Associate Chief of Staff/Education, Chief Medical Service, Chief Surgical Service, Chief Mental Health Service, Nurse Practitioner Representative (for matters involving nurse practitioners); Physician Assistant Representative (for matters involving physician assistants); Certified Registered Nurse Anesthetist (CRNA) (for matters involving CRNAs); Chief Human Resource Management Service or designee, Administrative Assistant to the Chief of Staff; and Medical Staff Coordinator

3. Meetings: The Professional Standards Board will meet at the call of the COS.

R. **PEER REVIEW COMMITTEE:**

1. Charge: The Peer Review Committee sets forth the requirements for initiating, conducting, and documenting peer review for quality management of care provided by individual providers. The Peer Review Committee has ultimate oversight of

the peer review process, The Peer Review Committee reports aggregate data to the CEB (CEB) and the VISN 9 Quality Management Officer (QMO) quarterly (See Policy memorandum 00-75, Peer Review for Quality Management.

2. Composition: The Peer Review Committee is multidisciplinary and consists of senior members of key clinical disciplines, as well as the facility risk manager. The Co- Chairs of the Committee are the COS and the Associate Medical Center Director for Patient Care Services, Nurse Executive; a Nursing Service Representative, Nurse Managers; a Surgical Service Representative – Surgeon; a Medical Service Representative – Internal Medicine; Medical Service Representative – Cardiologist; a Medical Service Representative – Pulmonologist; Medical Service Representative / Proceduralist – Gastroenterologist; an Ambulatory Care Representative – Emergency Medicine; a Pharmacy Service Representative; and a Social Work Service Representative. Periodically, ad hoc members will be asked by the Chief of Staff, or designee, to participate in Peer Review Committee proceedings. Legal counsel will serve as technical advisor, as appropriate.

3. Meetings: Monthly, no less than ten times per year.

S. MEDICAL RECORDS COMMITTEE:

1. Charge: The Medical Records Committee will utilize record reviews to determine the completeness, timeliness, general quality, and clinical pertinence of patient medical records. This will include the review of medical records of patients currently hospitalized as well as those of patients discharged from the medical center and outpatients.

2. Composition: Chief of Staff or designee; Neurology Service Physician Representative; Spinal Cord Injury Service, Physician Representative or designee; Surgery Service, Physician Representative or designee; Business Office, Chief, Health Information Management Section; Medical Service, Physician Representative; Ambulatory Care Service, Physician Representative or designee; Nursing Service, Associate Nurse Executive, Acute Care; Nursing Service, Registered Nurse Representative; Mental Health Service, Physician Representative; Compliance Officer; Clinical Application Coordinator; Patient Safety Officer, QM&I; Utilization Review Nurse, QM&I; and the Administrative Assistant to the Chief of Staff.

3. Meetings: Monthly, no less than ten times per year.

T. RESEARCH & DEVELOPMENT (R&D) COMMITTEE:

1. Charge: The R&D Committee serves in an advisory capacity to the Medical Center Director, through the Chief of Staff, on the professional and administrative aspects of the Medical Research, Health Services Research and Development, Cooperative Studies, and the Rehabilitation Research and Development Programs. The members of the R&D Committee are appointed by the Medical Center Director in writing and must reflect the types and amount of research being conducted at the

facility. Nominations for membership may be from current R&D Committee members, subcommittee members, and the facility's staff.

2. Composition: The R&D Committee must consist of at least five voting members. At least two members from the VA facility's staff who have major patient care or management responsibilities. At least two members who are VA investigators actively engaged in major R&D programs or who can provide R&D expertise. At least one member who holds an academic appointment, and is either a full-time Federal employee or a part-time permanent Federal employee. All voting members must be compensated full-time, part-time Federal or without compensation (WOC) government employees. Ex officio members without vote are the Medical Center Director; the Chief of Staff; the Administrative Officer/Director of Operations (AO/DO) for R&D; the Research Compliance Officer (RCO); the Facility Privacy Officer; the Facility Information Officer (ISO) and the Secondary Information Security Officer (SICO). Ex officio members with vote are the ACOS for R&D who will also serve as the Executive Secretary; and the Chairpersons of the subcommittees (IRB, Biosafety / Biosecurity and IACUC).

3. Meetings: Monthly, no less than ten times per year.

U. RESIDENT SUPERVISION:

1. Charge: A local monitoring process exists for resident supervision. The ACOS/Education is responsible for ensuring there are appropriate ongoing monitors of resident supervision. Samples of medical records will be reviewed by the Health Information Management personnel under the Business Office (BO). The VAMC Memphis Compliance Officer, Chief of Business Office, and Health Information Management Section (HIMS) will ensure appropriate reporting to service chiefs and/or the Chief of Staff based on these ongoing monitoring processes.

2. Composition: ACOS/Education, VAMC Memphis Compliance Officer, Lead Clinical Application Coordinator, and the Chief Health Information management, or designee *<Insert a description of the members of the committee>*.

3. Meetings: Monthly, no less than ten times per year.

V. RADIATION SAFETY COMMITTEE (RSC):

1. Charge: To provide oversight for the safe use of radioactive materials to ensure occupational and public radiation doses are as low as reasonably achievable (ALARA). Prepare records and reporting committee results as required by executive management and/or Title 10 Code of Federal Regulations (CFR) 35; and ensuring the records document executive management approvals for actions under 10 CFR 35 (e.g., 35.24 and 35.26). The RSC shall review, at least every 3 months, occupational and public doses. The RSC shall review, at least every 3 months, any identified health and safety issues or possible radiation safety program deviations from regulatory compliance or required practices. (Reference Policy Memorandum 00-91 RADIATION SAFETY PROGRAM

2. Composition: Radiation Safety Officer, Management Representative, Nuclear Medicine, Representative, Cardiology Service Representative, Radiology Service Representative, Biomedical Service Representative, Nursing Service Representative, Research Service Representative and an Oncology Representative.

3. Meetings: This committee meets quarterly, no less than three times per year.

W. SURGERY/INVASIVE PROCEDURE COMMITTEE: SURGICAL CASE AND QUALITY IMPROVEMENT COMMITTEE

1. Charge: The Surgical Case and Quality Improvement Committee will perform systematic reviews of surgical operations and invasive and non-invasive procedures that place patients at risk. The reviews are performed in order to improve the appropriateness and effectiveness of such procedures. The committee will also perform systematic reviews to assess efficient utilization of the operating rooms and appropriate and effective care of patients in the Surgical Intensive Care Unit (SICU). The SCQIC has oversight responsibility for reviewing, assessing, and measuring key processes related to operative, invasive, and noninvasive procedures.

2. Composition: Surgical Service, Director Surgical QA; Anesthesiology Service, Chief; Pathology and Laboratory Medicine Service, Director Surgical Pathology; Surgical Service, Chief, Neurosurgery Section; Surgical Service, Chief, Ophthalmology Section; Surgical Service, Chief, Orthopedic Surgery; Surgical Service, Chief, Otolaryngology Section; Surgical Service, Chief, Surgery Intensive Care Unit; Surgical Service, Chief, Thoracic Surgery; Surgical Service, Chief, Plastic Surgery Section; Surgical Service, Chief, Urology Section ; Surgical Service, Chief, Vascular Surgery; Nursing Service, Supervisor Operating/Recovery Rooms; Infection Control Nurse (ex- officio); Risk Manager, QM&I Representative (ex-officio); Surgical Service Quality Management Coordinator (ex-officio); Surgical Service, QA Liaison/Research Nurse (ex-officio); Surgical Service, Chief Cardiac Surgery.

3. Meetings: Quarterly.

X. VETERAN HEALTH EDUCATION (VHE) COMMITTEE:

1. Charge: The VHE is a multidisciplinary committee. Its purpose is to coordinate, facilitate, and monitor the development of veteran health education programs and activities, and to make recommendations regarding veteran health education policies and procedures to the medical staff through the CEB.

2. Composition: The members of this committee are: Education Service Representative, Librarian, Education Service Representative, Veteran Health Education Coordinator, Diabetic Educator, Nurse Practitioner, Medical Service Representative, General Medicine Physician, Nursing Service Representative, Nurse Practitioner, Mental Health Service Representative, Psychology Section, Ph.D., Nursing Service Representative, Cardiac Rehabilitation Nurse, Nursing Service Representative, Nurse Manager, RN, Nursing Service Representative, Program Support Clerk, Nutrition and Food Service Representative, Registered Dietitian, Pharmacy Service Representative, Pharm. D., Rehabilitation Service Representative, Nursing Service Representative, Surgical Nurse Liaison, RN, Ambulatory Care Representative, Women Veteran

Coordinator, Ambulatory Care Representative, Customer Service Representative, and Medical Media Section Representative.

3. Meetings: Monthly, no less than ten times per year.

Y. WOMEN VETERANS ADVISORY COMMITTEE:

1. Charge: The Women's Veterans Advisory Committee (WVAC) serves in an advisory capacity to management on all matters pertaining to women veteran's health care needs. Specific responsibilities of the committee are to identify areas of need in women veteran's health care and determine priorities for development of policies and programs to meet these needs; act in an advisory capacity to the Coordinator of the Women Veteran's Program; evaluate the effectiveness of the Women Veteran's health care delivery system; encourage development of clinical and educational programs to meet the health care needs of women veterans; market the available services and resources for women veterans.

2. Composition: The members of the WVAC are - the Women Veterans Program Manager, Chairperson, Chief Nurse, Clinical Operations, Medical Director, Women's Center, Chief, Social Work Service, Staff Chaplain, Assistant Chief, Business Office, Physician, Gynecological Service, Pharmacy Representative, Pharm.D., Director, Quality Management and Improvement, Veteran Representative, Readjustment Counselor, Vet Ctr., Director, Univ. Health Services/Prof. UT (Nsg.), and Staff Psychologist.

3. Meetings: Monthly, no less than ten times per year.

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, at a frequency determined by the Chief of Staff.

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

3. Each committee shall review and forward to the CEB, a synopsis of any subcommittee and/or workgroup findings. The frequency of this synopsis is to be determined by the Chief of Staff.

Section 5.05 Establishment of Committees

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

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

ARTICLE VI - MEDICAL STAFF MEETINGS

1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least annually. A record of attendance shall be kept.

2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the CEB or at the request of the Medical Center Director. 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 Medical Center Director in writing and stating the reason(s) for the request.

3. Quorum: For purposes of Medical Staff business, *no* less than twenty-five (25) percent of the total membership of the medical staff membership entitled to vote constitutes a quorum.

4. Meeting Attendance: Members of the Medical Staff are expected to attend 100% of regular Medical Staff meetings and 75% of Service-level meetings.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

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

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

C. Deployment/Activation Status:

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

2. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the CEB for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and CEB to put a FPPE in place to support current competence. The Medical Center Director has final approval for restoring privileges to active and current status.

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

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

D. 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:

1. 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.

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

E. Initial Focused Professional Practice Evaluation:

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

(a) Criteria for conducting performance monitoring

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

(c) Method for determining the duration of the performance monitoring

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

2. An initial Medical Staff appointment does not equate to HR employment. For full time physicians and dentists, the initial probationary period is two years. FPPE does

not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below;

(a) 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.

(b) 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.

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

1. The timeframe for OPPE monitoring is to be no greater than six months, unless clinical activity is so limited that a meaningful review cannot be achieved in the six (6) months time frame. Reviews may be based on a period of time or a specified number of procedures, and may consider high risk or high volume for an adjustment to the frequency.

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

3. In those instances where a practitioner does not meet established criteria, the service chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal

of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.

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

5. The Medical Center 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

A. Completed Application:

1. **NOTE**: Medical Staff appointment does not equate to HR employment. If provider is to also be an employee, the facility should cross reference to Human Resource Management Policies. Distinction should also be made between the Title 38, Title 38 Hybrids, and Title 5 providers.

2. Applicants for appointment to the Medical Staff must submit a complete application. When applying for VA and other Federal positions, you can submit a resume, curriculum vitae, or Optional Application for Federal Employment (OF-612). The format you choose for your application is up to you, but it must include some specific information for you to receive proper consideration. The following information is required to evaluate applicant qualifications and to determine whether applicants meet legal requirements for Federal employment:

(a) The Announcement number and title and grade(s) of the job for which you are applying.
(b) Full name, mailing address (with zip code), and day and evening phone numbers.
(c) Social Security Number (only the last four digits may be required).
(d) Country of Citizenship (most federal jobs require US citizenship).
(e) Veterans preference (A DD-214 is required).
(f) Reinstatement eligibility (if requested, attach SF-50 proof of your career or career-conditional status).
(g) Highest federal civilian grade held (also give job series and dates held).
(h) High School. Include name, city and state, and date of diploma or GED
(i) College or University. Include name, city and state, majors, and any degrees awarded (only send college transcripts if the position specifies to do so).
(j) Provide the following information for your paid and non-paid work experience related to the job you are applying for: job titles (include series and grade if a federal job); duties and accomplishments; employer's name and address; supervisor's name and phone number; starting and ending dates (month and year); hours per week and salary.

(k) Indicate whether your current supervisor can be contacted.

(l) Job-related training courses (title and year).

(m) Job-related skills, for example, other languages, computer software/hardware, tools, machinery, typing speed.

(n) Job-related certifications and licenses (current only).

(o) Job-related honors, awards, and special accomplishments, for example, publications, memberships in professional or honor societies, leadership activities, public speaking, and performance awards (give dates, but do not send).

(p) Since traditional resumes do not provide all the information needed to determine your qualifications for Federal positions, you should create a more detailed resume to use when applying for Federal positions.

3. The applicant is bound to 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 Practitioner says the information provided is factually incorrect.

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

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

(2) Education.

(3) Relevant training and/or experience.

(4) Current professional competence and conduct.

(5) Physical and Mental health status.

(6) English language proficiency.

(7) Professional liability insurance (contractors only).

(8) BLS approved program using criteria by the American Heart Association. Clinically active staff nominally includes all staff physicians, mid-level providers and nurses, but facilities are encouraged to consider more broad training opportunities including non-clinical staff. Contract staff should have required BLS training and certification as part of their contracts. Consulting physicians should have BLS and ACLS training and certification based upon Service Chief recommendations. Without compensation physicians are strongly encouraged, but not required, to have BLS or ACLS training and certification

(9) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and ACLS certification.

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

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

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

(1) Name of health care institution or practice.

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

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

(e) DEA/CDS Registration: A description of:

(1) Status, either current or inactive.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 7.03 Process and Terms of Appointment

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

B. VISN 9 Executive Review: In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be submitted to the VISN 9 Executive Review Board (ERB) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the CEB, if the response from the NPDB-HIPDB query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of $550,000 or more, or (c) two medical malpractice payments totaling $1,000,000 or more. The higher level review by the VISN 9 ERB 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 9 ERB 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 9 ERB's review will be documented on the Service Chief's Approval screen in VetPro as an additional entry. Review by the VISN 9 ERB is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

C. CEB Recommendation: CEB recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

D. Medical Center Director Action: Recommended appointments to the Medical Staff should be acted upon by the Medical Center Director within 30 work days of receipt of a fully complete application, including all required verifications, references and recommendations from the appropriate Service Chief and *<Insert name of committee that serves as executive committee of the medical staff>*.

E. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of

appointment or non-appointment, or return of the application because of inadequate information.

Section 7.04 Credentials Evaluation and Maintenance

A. Evaluation of Competence: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the Practitioner applying for clinical privileges has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.

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

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

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

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

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

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

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

(1) Criteria for conducting the FPPE.

(2) Method for monitoring for specifics of requested privilege.

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

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

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

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

(1) Extension of FPPE review period

(2) Modification of FPPE criteria

(3) Privileges (initial or additional) may be suspended for the duration of a review (appropriate due process will be afforded to the Practitioner)

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

Section 7.05 Local/VISN-Level Compensation Panels

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

ARTICLE VIII CLINICAL PRIVILEGES

Section 8.01 General Provisions

A. Clinical privileges are granted for a period of no more than 2 years; however, for contract and or locum tenens practitioners, clinical privileges may not exceed beyond the known period of the relationship, i.e., the length of the contract.

B. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.

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

2. 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 CEB. The verification date of a time- limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7).

C. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Service Chief, who will forward to the Clinical Privileges committee for processing.

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

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

F. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all Service Chiefs must recommend the practice.

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

H. 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, unless otherwise approved by CEB

I. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

J. Teleconsultation: All Practitioners providing teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

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

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

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

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

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

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

4. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Medical Staff. Reasonable evidence of health status may be required by the <Insert name of committee that serves as executive committee of the medical staff>.

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

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

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

8. 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.

9. Evidence of successful completion of an approved BLS or ACLS program meeting the criteria of the American Heart Association.

D. 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.

E. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

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

1. 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 VAMC Memphis missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.

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

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

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

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

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

7. 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.

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

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

1. Current and previously held licenses in all states.
2. Current and previously held DEA/State CDS registration.
3. NPDB-HIPDB PDS Registration.
4. FSMB query
5. Physical and mental health status information from applicant.
6. Physical and mental health status confirmation.
7. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and FPPE.
8. Continuous education to meet any local requirements for privileges requested.
9. Board certifications, if applicable.
10. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges

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

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

C. Current NPDB-HIPDB PDS Registration prior to rendering a decision.

D. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the CEB followed by the Medical Center Director's approval.

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

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

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

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

(a) Medical/Clinical knowledge (education competency).

(b) Interpersonal and Communication skills (documentation; patient satisfaction).

(c) Professionalism (personal qualities).

(d) Patient Care (clinical competency).

(e) Practice-based Learning & Improvement (research and development).

(f) System-based Practice (access to care).

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

C. The CEB recommends granting clinical privileges to the VAMC Memphis Medical Center Director based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. The Clinical Privileges Committee, a subcommittee of the CEB, can make the initial review and recommendation but this information must be reviewed and approved by the CEB.

D. Clinical privileges are acted upon by the Medical Center Director within 30 calendar days of receipt of the CEB recommendation to appoint. The Medical Center Director's action must be verified with an original signature.

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

F. The VAMC Memphis also has a defined approval process for the scopes of practice and prescriptive authority for Mid-Level and Associate Health Practitioners. This process is facilitated through the Medical Staff Office and/or the Service Office of the practitioner.

Section 8.06 Exceptions

A. 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 Medical Center Director or Acting Medical Center Director on the recommendation of the Chief of Staff.

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

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

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

(c) Current comparable clinical privileges at another institution.

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

(e) Response from FSMB with no reports.

(f) No current or previously successful challenges to licensure.

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

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

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

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

B. Expedited Process:

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

2. The VAMC Memphis:

(a) Verifies education and training;

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

(c) Receives confirmation on the declaration of health, by a physician designated by or acceptable to the VAMC Memphis, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;

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

(e) 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.

(f) Verifies current comparable privileges held in another institution; and

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

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

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

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

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

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

4. The recommendation by the delegated subcommittee of the CEB must be acted upon by the VAMC Memphis' Medical Center Director.

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

C. 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 VAMC Memphis's affiliated residency training programs.

D. Disaster Privileges: As described in the VAMC Memphis's Emergency Management Plan:

1. In the event of the activation of the emergency management plan, Disaster Privileges may be approved by the Medical Center Director, the Chief of Staff, or in their absentia, the individual that is acting in that capacity if it is determined that it is not possible to handle the influx of patients with the existing Practitioners. Any of the following will be accepted as credentials verification process for emergency volunteers to provide patient care in the VAMC Memphis:

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

(b) And one of the following:

(1) A current medical facility photo ID card.

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

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

2. The documentation will serve as credentials verification for a period not to exceed ten (10) calendar days or length of the disaster, whichever is shorter. Primary

source verification of licensure will be obtained within seventy-two (72) hours after the disaster is under control, or as soon as possible in extraordinary circumstances.

3. In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the 10 calendar days or the length of the declared disaster, whichever is shorter, noted in paragraph b above, the Practitioner 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.

4. An assigned, appropriately credentialed and privileged physician oversees the professional practice of each volunteer, Licensed Independent Practitioner, Mid-Level Practitioner, and Allied Health Practitioner.

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

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

1. When the Practitioner returns to the VAMC Memphis, 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.

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

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

1. Practitioners returning from active duty are requested to communicate with the appropriate Service Chief and/or the Medical Staff Coordinator's office as soon as possible upon returning to the area.

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

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

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

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

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

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

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

(a) Verification 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.

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

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

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

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

ARTICLE IX INVESTIGATION AND ACTION

1. Request for Investigation: Whenever the behaviors, activities and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, to be

lower than the standards of the Medical Staff, or to represent Professional Misconduct, behavior or behaviors that undermine a culture of safety, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Medical Center Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct, which constitute the grounds for the request. The Chief of Staff promptly notifies the Medical Center Director in writing of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. <***NOTE***: *If the person under review, is an employee then the processes must also follow VA Directive 5021 - Management of Employees (Appendix A pages 2-9).*>

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

3. Review by Professional Standards Board: The Professional Standards Board (PSB) investigates the charges and makes a report of the investigation to the CEB within 14 days after the PSB has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the PSB to discuss, explain or refute the charges against him/her. 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 PSB 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 CEB.

4. The CEB Action: Within 14 days after receipt of a report from the PSB, the CEB act upon the request. If the action being considered by the CEB involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the CEB 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 CEB.

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

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

(c) Reduction of privileges may include, but not be limited to, functioning under supervision[1], restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.

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

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

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

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

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

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

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

(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.

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

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

(4) Failure to maintain the mandatory requirements for membership to the medical staff.

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

(c) Immediately upon the occurrence of an Automatic Suspension, the Service Chief or the Chief of Staff provides alternate medical coverage for the Veterans of the suspended Practitioner.

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

7. Union Representation: When the Practitioner is a member of the bargaining unit, he/she has the right to representation in the interview processes described in paragraphs 1 through 6 of this Article IX.

8. Actions Not Constituting Corrective Action: The Professional Standards 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 Practitioner to appear at an interview or conference before the Clinical Privileges 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 Veterans;

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

(g) Corrective counseling;

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

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

ARTICLE X FAIR HEARING AND APPELLATE REVIEW

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

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

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

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

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

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

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

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

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

(a) Be present throughout the evidentiary proceedings.

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

(c) Cross-examine witnesses.

(d) The Practitioner has the right to purchase a copy of the transcript or tape of the hearing.

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

D. 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 VAMC Memphis Medical Center Director for extraordinary circumstances or cause.

1. The panel's report, including findings and recommendations, must be forwarded to the VAMC Memphis Medical Center Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

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

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

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

5. The decision of the VISN Medical Center 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. Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.

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

F. Practitioner Rights:

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

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

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

4. The Practitioner may submit a written appeal to the VISN Director within five (5) workdays of receipt of the Medical Center Director's decision.

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

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

7. The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.

8. If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, if greater than thirty (30) days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

G. Revocation of Privileges:

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

(a) 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.

(b) 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.

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

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

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

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

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

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 when a tort claim settlement is submitted for review.

5. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physician and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4 The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional

[2] Reference VHA Handbook 1100.17.

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

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, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Medical Center Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

ARTICLE XI RULES AND REGULATIONS

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

ARTICLE XII AMENDMENTS

A. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from the CEB. Changes to the bylaws are amended, adopted by (1) the affirmative vote of the majority of Medical Staff members, who are eligible to vote and present at a general meeting of the Medical Staff, or (2) a two thirds vote of the CEB. The CEB 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 Medical Staff for review. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.04 should be followed.

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

C. All changes to the Bylaws require action by both the Medical Staff and VAMC Memphis Medical Center Director. Neither may unilaterally amend the Bylaws.

D. Changes are effective when approved by the Medical Center Director.

ARTICLE XIII - MEDICAL STAFF RULES AND REGULATIONS

A. GENERAL

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

2. 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.

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

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

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

6. These Rules and Regulations are considered extensions of various Medical Center policy memoranda. These policy memoranda are available to all staff directly for review upon request, through their service chiefs, from the office of the Chief of Staff, or can be located electronically on the VAMC Memphis' Intranet home page - http://vaww.memphis.va.gov/.

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

B. PATIENT RIGHTS

1. Patient's Rights and Responsibilities: The VAMC Memphis supports the rights of each patient and publishes policy and procedures to address rights including each of the following:

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

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

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

(d) Pain management including assessment, treatment and education.

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

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

(g) 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.

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

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

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

(k) Personal privacy and confidentiality of information.

(l) 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.

(m) Authority of 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).

(n) Foregoing or withdrawing life-sustaining treatment including resuscitation.

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

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

(a) 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.

(b) 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).

(c) 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.

(d) 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.

(e) 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.

(f) 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:

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

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

(3) 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.

C. RESPONSIBILITY FOR CARE

1. Conduct of Care

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

(1) 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.

(2) For elective surgical procedures, a medical history and physical examination is completed within 30 days before admission, the practitioner 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, a oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA regulations and hospital policy. The content of complete and focused history and physical examination is delineated in Section C: Responsibility for Care, of the Medical Staff Rules and Regulations.

(3) Medical Assessment of the patient shall include: Medical history, including:

a Chief complaint

b Details of present illness

c Relevant past, social and family history d Review of systems

e Summary of the patient’s psychological needs, as appropriate

f Report of relevant physical examinations

g Statement on the conclusions or impressions drawn from the admission history and physical examination

h Statement on the course of action planned for this episode of care and its periodic review

i 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, intern, or Mid-Level Practitioner, and write a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" and make whatever comments he/she thinks the case warrants, or prepare a complete admission note within forty eight (48) hours of admission to the medical center. In the event a resident, intern, or Mid-Level Practitioner prepares an admission workup, all 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 VAMC Memphis policy 11-27 RESIDENT SUPERVISION and/or the VHA Handbook 1400.1, Resident Supervision.

(5) 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.

(6) 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.

(7) Progress notes will be written by the Practitioner at least once daily on all acutely ill patients. Progress notes are written for all patients seen for ambulatory care by the medical staff.

(8) 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. 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.

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

(10) Patients will not be transferred out when the VAMC Memphis 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 VAMC Memphis policy.

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

(c) There is to be a comparable level of quality of surgical and anesthesia care throughout the VAMC Memphis.

2. Consultations:

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

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

(2) The diagnosis is obscure, and/or

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

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

(c) 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.

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

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

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

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

(b) Discharge planning is documented in the medical record.

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

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

4. Discharge:

(a) Patients shall be discharged from the VAMC Memphis only upon the written order of the physician and the discharge summary should be dictated no later than the day of discharge. At time of dictating the final summary, the responsible member of the Medical Staff shall review the medical record to ensure that documents therein pertain to the patient and contain accurate data. The record shall be completed within 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.

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

5. Autopsy:

(a) Autopsy services are provided in the facility by VAMC Memphis. 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 VAMC Memphis.

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

(c) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.155 and VAMC Memphis policy memorandum 11-31 Autopsy Services (which includes Criteria for assignment to medico-legal status).

(d) Autopsy Rates. Autopsies are encouraged as per VHA policy.

(e) Autopsy Criteria. VHA policy encourages autopsies be requested from next- of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in VAMC Memphis policy memorandum 113-05, Procedures for Autopsies. 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.

(f) 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.

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

D. PHYSICIANS' ORDERS

1. General Requirements

(a) Orders are entered into the electronic medical record, commonly called the Computerized Patient Record System (CPRS).

(b) Verbal orders are strongly discouraged except in urgent or emergency situations.

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

2. Medication Orders

(a) All drugs used at the VAMC Memphis 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 VAMC Memphis Medication Use 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. All drugs used at the VAMC Memphis will be stored and dispensed by the Pharmacy.

(b) Duration of Orders:

(1) 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 CPRS for each succeeding period of 14 days or less.

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

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

(4) 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.

(c) Ambulatory Care Medication Orders:

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

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

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

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

(d) Transfer of Patients: All active orders will follow the patient to the new location when a patient is transferred. The provider is responsible for reviewing all existing orders and making changes. All drug and text orders are to be reviewed and

rewritten as needed when a patient is transferred to or from different services. This is to include discontinuing orders that are no longer needed and adding new orders.
Patients that stay within a treating specialty will not require orders to be rewritten. Delayed Transfer orders are not required unless the patient is transferring to or from a mental health inpatient ward. Providers that are transferring patients to a mental health inpatient ward are to use the mental health transfer delayed order process. See policy memorandum 11-15 Medical Care Orders

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

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

5. Informed Consent:

(a) Informed consent will be consistent with legal requirements and ethical standards, as described in VAMC Memphis Policy Memorandum 11-11, Informed Consent.

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

6. Submission of Surgical Specimens: All tissues and objects except teeth removed at operation shall be sent to the VAMC Memphis pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

7. Special Treatment Procedures:

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

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

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

(3) Documentation in the medical record.

(4) Requirements are described in VAMC Memphis Policy Memorandum 11-46, Do Not Resuscitate (DNR) Protocol, Medical Staff Bylaws, and these Rules.

(b) Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and may be utilized only within the guidelines of an established protocol in the Policy Memorandum 11-35 Use of

Sedation and Analgesia related to Sedation/Analgesia and only by those Practitioners with approved and current privileges to do so.

E. ROLE OF ATTENDING STAFF:

1. Supervision of Residents and Non-Physicians

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

3. 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.

4. Mid-Level and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

5. Documentation of Supervision of Resident Physicians

(a) 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 VAMC Memphis Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.

(b) Entries in the medical record made by residents or those non-physicians (e.g., PAs, ARNPs, etc.) that require countersigning by supervisory or attending medical staff members are covered by appropriate policy; Supervision of dental, medical, optometry, and podiatry residents is covered in VHA Handbook 1400.1, Resident Supervision and policy memorandum 11-27, Resident Supervision and non-physicians are covered in policy memorandum 11-59 and 11-60. and include:

(1) Admission history and physical examination.

(2) Discharge Summary.

(3) Operative Reports.

(4) Medical orders that require co-signature. a DNR.

b Withdrawing or withholding life sustaining procedures. c

Certification of brain death.

d Research protocols.

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

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

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

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

F. MEDICAL RECORDS

1. Basic Administrative Requirements:

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

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

(c) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in VAMC Memphis Policy Memorandum 11- 50 Approved and Unapproved Medical Abbreviations and is available in CPRS and VISTA.

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

(e) Release of information is required per Policy Memorandum 136-43 Privacy and Release of Information and standard operating procedures for the VAMC Memphis.

(f) All medical records are confidential and the property of the VAMC Memphis and shall not be removed from the premises without permission (release of information from the Patient/consultation with the privacy officer as appropriate). Medical records may be removed from the VAMC Memphis' 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.

(g) 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.

2. All Medical Records must contain:

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

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

(c) Observations, including results of therapy.

(d) Diagnostic and therapeutic orders.

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

(f) Progress notes.

(g) Consultation reports.

(h) Diagnostic impressions.

(i) Conclusions at termination of evaluation/treatment.

(j) Informed consent before procedures or treatments are undertaken and if not obtainable, the reason, as stated in VAMC Memphis Policy Memorandum 11-11, Informed Consent.

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

(a) 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, and review of systems;

(b) A complete physical examination includes (but not limited to) general appearance, examination of body systems, nutritional status, ambulation, mentation, 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.

(1) 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.

(2) Inpatient H & P must be completed within 24 hours.

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

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

(e) Completed within 30 days of discharge.

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

(a) A progress note for each visit.

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

(c) Patient disposition and instruction for follow-up care.

(d) Immunization status, as appropriate.

(e) Allergies.

(f) Referrals and communications to other providers.

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

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

5. Surgeries and Other Procedures:

(a) 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.

(b) Preoperative Documentation:

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

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

(3) 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.

(4) 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.

(c) Immediate Post-Operative Documentation: A post-operative progress note must be written, or directly entered into the patient's health record, by the surgeon

immediately following surgery and before the patient is transferred to the next level of care.

(1) The immediate post-operative note must include: a Pre-operative diagnosis,

b Post-operative diagnosis,

c Technical procedures used, d Surgeons,

e Findings,

f Specimens removed, and g Complications.

(2) The immediate post-operative note may include other data items: a Anesthesia,

b Blood loss, c Drains,

d Tourniquet Time, or e Plan.

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

(e) Post Anesthesia Care Unit (PACU) Documentation:

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

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

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

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

G. INFECTION CONTROL

The Infection Control Program is facility-wide and assures a sanitary environment to prevent, identify, and control infections that may develop among patients, visitors, employees, volunteers, and students. The Infection Control Program has a broad scope, which includes activities at the direct patient care level and patient care support level. The entire program is outlined in the Infection Control Manual. Isolation Guidelines, Standard Precautions, and Reportable Cases are described in Infection Control Policy

H. 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 VAMC Memphis are documented and verifiable at the time of reappraisal and re-privileging.

I. 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.

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

2. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the Physical Standards Board.

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

4. VA and VAMC Memphis 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.

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

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

J. PEER REVIEW

1. All Medical Staff members shall participate in the VAMC Memphis protected peer review program established by Policy Memorandum 00-75, Peer Review for Quality Management.

2. All Medical Staff members will complete ongoing required training associated with Peer Review.

K. SMOKING POLICY:

1. In accordance with the Veterans Health Administration (VHA) smoke-free policy, smoking or use of any tobacco product is prohibited inside this facility and in Government-owned vehicles;

2. Because of the indisputable evidence that smoking and exposure to environmental tobacco smoke are detrimental to good health, it is the public policy position of VHA and medical center leadership that smoking is inconsistent with our responsibility for the treatment and prevention of illness. Patients, employees and the community will be advised, influenced and educated regarding the nature and magnitude of the health hazards of smoking and the use of smokeless tobacco products;

3. Smoking is also prohibited on contiguous facility grounds except in designated smoking shelters for staff, visitors and patients.

4. Patients, employees, volunteers, visitors or any other persons are not permitted to smoke, use, or display any tobacco product including cigarettes, cigars, and pipes in any location within the medical center. This prohibition includes the display of unlit tobacco products and the use of smokeless tobacco products;

5. The distribution of free cigarettes or other tobacco products to patients is not permitted; In consideration of the addictive nature of nicotine and the difficulty of overcoming tobacco dependence, smoking cessation programs will be available for patients and employees; See Policy Memorandums 00-51 SMOKE-FREE ENVIRONMENT and 00-78 SMOKING FIRE HAZARD REDUCTION WHEN OXYGEN TREATMENT IS EXPECTED FOR INPATIENTS.

L. REQUIREMENTS FOR CPR CERTIFICATION (BLS OR ACLS):

All clinically active staff will have CPR education, whether through the AHA Basic Cardiac Life Support (BLS) for Healthcare Providers or through another similar program that includes both CPR and use of public access AED. In general all full-time, part-time, and fee-based physicians should receive training and certification. Contract physicians should have BLS and/or ACLS training and certification specified in the contract.
Service chiefs may identify consulting physicians requiring BLS/ACLS. Service Chiefs may exclude certain physicians from this training based upon lack of clinical contact or medical reasons. Required BLS training for psychologists, pathologists, optometrists, and podiatrists is determined by the respective Service Chief: See Policy Memorandum 11-51 CARDIOPULMONARY RESUSCITATION (BLUE ALERT) POLICY.

M. DISCLOSURE POLICY:

The Memphis VA Medical Center and respective providers have an obligation to disclose adverse events to patients who have been harmed in the course of their care, including cases where the harm may not be obvious or severe, or where the harm may only be evident in the future. The patient is free to involve family members in the disclosure process. NOTE: If the patient is deceased, incapacitated, or otherwise unable to take part in a process of adverse event disclosure, the process needs to involve the patient's representative and anyone who is designated by the representative; Policy Memorandum 00-74 DISCLOSURE OF ADVERSE EVENTS TO PATIENTS.

N. QUALITY MANAGEMENT:

The VAMC Memphis strives to ensure the scope of the Quality Management System (QMS) is medical center-wide and includes VA Staffed and Contracted Community Based Outpatient Clinics. It is organized, systematic, and requires the continuous effort by all services and all employees to achieve excellence in delivery of health care services and a safe environment. This is accomplished by identifying deficiencies, evaluating and maintaining internal controls, implementing improvements, measuring outcomes, and analyzing trends. The QMS emphasizes accountability of all medical center personnel for appropriateness of patient care, treatment and services provided, effective utilization of resources, patient, employee and visitor safety; Policy Memorandum 00-12 QUALITY MANAGEMENT SYSTEM.

O. REQUIREMENT FOR TIME AND ATTENDANCE:

It is the policy of the VAMC Memphis in regards to Part-time Physician services to procure said services through the employment or contracting authority that best suits their anticipated utilization; Policy Memorandum 11-28 TIME AND ATTENDANCE PROCEDURES FOR PART-TIME PHYSICIANS.

P. PATIENT SAFETY INITIATIVES:

It is the policy of the VAMC Memphis to ensure that quality patient care and services will be provided in an environment that is structured to identify, investigate and minimize risk to patients, visitors and staff. The goal of this program is to minimize the chance of untoward outcomes related to medical care; Policy Memorandum 00-11 PATIENT SAFETY IMPROVEMENT PROGRAM.

Q. CONFLICT OF INTEREST:

Business activities and health information practices will be conducted in accordance with all laws, regulations, and industry standards which apply in order to maintain the highest level of professional and ethical standards in the conduct of clinical and administrative operations; Policy Memorandum 00-23 COMPLIANCE AND BUSINESS INTEGRITY (CBI) PROGRAM.

R. RESTRAINT AND SECLUSION:

The VAMC Memphis will strive to become as restraint free as possible. Our commitment is to protect every patient's health and safety and to preserve their dignity, rights, and well-being. The training and competency of direct care staff as well as any other staff involved in the use of restraints and seclusion includes information regarding potential consequences of restraint use and is validated initially and annually. The use of restraint will be limited to occurrences in which there is an imminent risk of a patient harming him / herself or others, including staff. Restraints will be used only when non- physical interventions are ineffective or not viable. Restraint and/or seclusion shall never be used on an as needed basis, as coercion, discipline, punishment, or retaliation by staff or for the convenience of staff. The type of physical intervention selected will take into consideration information learned from the patient's initial assessment.
Alternative/least restrictive measures will be utilized in all cases. Employing the least restrictive method will provide safe and effective care to patients. Policy Memorandum 118-01 SECLUSION AND / OR RESTRAINT.

S. SUICIDE ASSESSMENT:

All Providers are responsible for assuring that all patients presenting with behavioral health issues are assessed for suicide risk as established in this policy. All non-Mental Health (MH) Providers are responsible for consulting MH in the management of all patients at risk for suicide. Emergency Room (ER) Providers must involve MH staff present in the ER or on-call for the ER in the assessment of all patients with behavioral health issues. (ER) MH providers will complete a risk assessment and safety plan on all referred mental health patients that check into the ER. The safety plan will be reviewed with the patient, significant other or family member(s) and a copy will be provided to the patient; Policy Memorandum 116A-12 MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE.

ARTICLE XIV ADOPTION

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

Originally adopted by the Medical Staff of VA Medical Center, Memphis, TN on February 28, 1995

Reviewed	February 1997
Reviewed and Revised	August 1998
Reviewed and Revised	December 2000
Reviewed and Revised	August 2001
Reviewed and Revised	August 2002
Reviewed and Revised	April 2003
Reviewed and Revised	June 2004
Reviewed and Revised	July 2005
Reviewed and Revised	October 2006
Reviewed	May 2007
Reviewed and Revised	October 2008
Reviewed	August 2010
Reviewed and Revised	November 2011

Recommended by:

Signature on File

CHRISTOPHER R. MARINO, MD
Chief of Staff

Approved:

Signature on File

JAMES ROBINSON, III, Psy.D
Medical Center Director

Form for Practitioner's Signature

I have read the Medical Staff Bylaws of the VA Medical Center Memphis, and agree to abide by them. I have been given a copy.

Signature of Practitioner Date

Printed Name of Practitioner

PRACTITIONER — PLEASE SIGN THIS FORM AND RETURN THE SIGNED FORM TO:

VAMC, MEMPHIS
MEDICAL STAFF COORDINATOR OFFICE (00B) 1030
JEFFERSON AVE.
MEMPHIS, TN 38104

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

MOUNTAIN HOME VA HEALTHCARE SYSTEM
MOUNTAIN HOME, TENNESSEE

REVIEWED DATE: AUGUST 3, 2015

REVISED DATE: AUGUST 3, 2015

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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 within the Mountain Home VA Healthcare System (MHVAHCS) 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.

MHVAHCS is a tertiary integrated healthcare system comprised of James H. Quillen VA Medical Center (JHQVAMC), a Community Living Center (CLC) and outpatient clinics located in Tennessee and Virginia. Portions of these bylaws are required by the VA, VHA, and/or The Joint Commission (TJC). These sections should be maintained in accordance with all current regulations, standards or other applicable requirements.

Prior versions of bylaws and rules and regulations must be maintained in accordance with Sarbanes-Oxley Act which states that bylaws and rules are permanent records and should never be destroyed. They must be maintained in accordance with Record Control System (RCS) 10-1, 10Q.

The MHVAHCS is committed to improving the health of our Veterans through a comprehensive and high quality healthcare system that focuses on each Veteran's unique needs. The integrated system provides an environment that fosters healthcare, research and encourages learning. Our vision is to be the healthcare system of choice where our patients choose to receive care and employees are proud to work. The values of this healthcare system are the core of all endeavors in fulfilling our mission to honor and serve America's Veterans by providing exceptional healthcare that is patient centered and preferred by Veterans. The core values of Integrity, Commitment, Advocacy, Respect, and Excellence (ICARE) serve as the foundation for our commitment to our Veterans.

The medical staff is required to comply with the medical staff bylaws, rules and regulations and policies. The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances, and taking action in others. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

DEFINITIONS

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

1. Advanced Practice Professional: Advanced Practice Professionals 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. Advanced Practice Professionals include: physician assistants (PA), and advanced practice nurses (ARNP, CRNA, and CRNP). Advanced Practice Professionals 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 Practitioner when required. Advanced Practice Professionals do not have admitting privileges and may initiate prescriptions for non-formulary medications or prescribe controlled substances in accordance with state of licensure statutes and regulations. Advanced Registered Nurse Practitioners and other health care professionals may be granted defined clinical privileges when allowed by law and the facility (this is a facility decision).

2. 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, Advanced Practice Professional and/or patient care services at the facility. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.

3. Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when serving in the capacity of Acting Medical Center Director.

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, audiologists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.

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

6. Chief of Staff: The Chief of Staff is the President of the medical staff and Chairperson of the Medical Executive Board and acts as full assistant to the Director in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioners, Advanced Practice Professionals, and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of medical staff.

7. Outpatient Clinic (OC): An outpatient clinic is a healthcare site whose location is either independent of the medical facility or located within the medical facility and

whose patient population is not admitted as an inpatient at the medical facility. The oversight of all outpatient clinics is assigned to a medical facility. An OC can be a site that is VA-operated and/or contracted. An OC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible Veteran patients. An OC must be operated in a manner that provides Veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures.

8. Credentialing: Credentialing is the systematic process of screening and evaluating qualifications and other credentials of applicants and biennially of existing staff to assure that they possess the required education, training, license, registration, certification, experience, and skill to fulfill the requirements of appointment.

9. Credentialing Committee: The Credentialing Committee is responsible for all credentialing and clinical privileging matters for the Medical Staff, makes recommendation on such matters to the Medical Executive Board as defined by these Bylaws. The Credentialing Committee may act on matters involving Associated Health and Advanced Practice Professionals, such as granting prescriptive authority, scope of practice, and appointment. The Chief of Staff is Chairman of the Credentialing Committee.

10. Medical Center Director: The Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Chief of Staff (COS), Deputy Chief of Staff (DCOS), the Associate Director (AD), and the Associate Director for Nursing/Patient Care Services (AD-NPCS).

11. Employee Assistance Program: The Employee Assistance Program provides confidential, face-to-face and telephonic assessments and short-term counseling services to employees in need of assistance with substance abuse, bio-psychosocial problems and life stresses.

12. Functional Statement: An official statement of the major duties and responsibilities assigned by management to a position. It must contain all pertinent information related to the position to ensure accurate job-related documentation. The following positions are included but not limited to: audiologist (unlicensed), biomedical engineer, dental assistant, dental hygienist, dietician, diagnostic radiologic technologist, kinesiotherapist, licensed practical nurse, medical instrument technician, medical record administrator, medical record technician, medical technologist, nuclear medicine technologist, clinical nurse specialist, occupational therapist, occupational therapy assistant, orthotist-prosthetist, pharmacist, pharmacy technician, physical therapist, physical therapy assistant, prosthetic representative, registered nurse, registered and certified respiratory therapist, social worker, speech pathologist, and therapeutic radiologist technologist.

13. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the Medical Center Director.

The Director is responsible for the oversight and delivery of health care by all employees and specifically including the medical staff credentialed and privileged by the relevant administrative offices and facility approved processes.

14. Impaired Practitioner: An individual who is credentialed and privileged to provide direct patient care or does so under a scope of practice or functional statement but is unable to provide such care because of physical illness, mental illness or substance abuse.

15. Just Cause: Just cause is a burden of proof or standard that an employer must meet to justify discipline or discharge. Also known as bare sagen, it is a common standard in labor arbitration that is used in labor union contracts in the United States as a form of job security. Typically, an employer must prove just cause before an arbitrator to sustain an employee's termination, suspension or other discipline. Usually, the employer has the burden of proof in discharge cases or if the employee is in the wrong.

16. Licensed Independent Practitioner: The term Licensed Independent Practitioner refers to any individual permitted by law and by the MHVAHCS to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians and dentists. It may also include individuals who can practice independently, who meet this criterion for independent practice.

17. Licensure: Licensure refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license or registration.

18. Medical Executive Board: Executive committee of the medical staff that is chaired by the Chief of Staff and empowered to act on behalf of the medical staff. It carries out its work within the medical staff functions of governance, leadership, and performance improvement activities.

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

20. Nurse Executive (Associate Director for Nursing/Patient Care Services): The Nurse Executive is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he is the Chairperson of the Patient Services Executive Board and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant Advanced Practice Professionals and certain associated health staff and in ensuring the ongoing education of the nursing staff.

21. Organized Medical Staff: The body of Licensed Independent Practitioners who are collectively responsible for adopting and amending medical staff bylaws (i.e., those with voting privileges as determined by the Facility as defined in these Bylaws) and

for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges.

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

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

24. Privileging: The process by which a licensed independent practitioner (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.) is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training and licensure. Privileges must be facility-specific and provider-specific.

25. Proactive Disclosure Service (PDS): Continuous monitoring service through the National Practitioner Data Bank (NPDB) that notifies subscribing entities when new or updated NPDB and/or Healthcare Integrity and Protection Data Bank (HIPDB) reports are received. PDS notifies subscribers of a report on their enrolled practitioners within 24 hours of receipt by the Data Bank.

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

27. Professional Assistance Board: The Professional Assistance Board is responsible for promoting the physical, personal, and professional well-being of the medical staff and may make appropriate referrals to the Employee Assistance Program.

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

29. Scope of Practice**:** Scope of practice is a term used by state licensing boards for various professions that define the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency.

30. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider.

31. 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.

32. 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).

33. VetPro**:** VetPro is an Internet enabled data bank for the credentialing of VHA health care providers that facilitates completion of uniform, accurate and complete credentials file.

ARTICLE I. NAME

The name of this organization shall be Mountain Home VA Healthcare System (MHVAHCS).

ARTICLE II. PURPOSE

The purposes of the Medical Staff shall be to:

1. Assure that all patients within the MHVAHCS receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.
3. Establish and assure adherence to ethical standards of professional practice and conduct.
4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the Medical Executive Board and the Governing Body in developing and maintaining rules for Medical Staff governance and oversight and provide a means whereby problems of a medical-administrative nature may be discussed by the Medical Staff and the Governing Body.
8. Provide a medical perspective, as appropriate, to issues being considered by the Director and Governing Body.
9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.
10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.
11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
12. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.

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

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

15. Ensure associated health professionals practice within their authorized functional statement.

16. Provide medical backup to the Department of Defense in times of emergency.

17. Initiate and pursue corrective action with respect to members where warranted.

18. Establish and amend, as needed the Medical Staff Bylaws, Rules and Regulations, and policies for the effective performance of Medical Staff responsibilities.

19. Enforce and comply with Medical Staff Bylaws, Rules and Regulations.

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 professionally competent, licensed physicians, dentists, optometrists, podiatrists, and clinical psychologists, audiologists, speech language pathologists, and chiropractors who continually meet the qualifications, standard and requirements of VHA, MHVAHCS, and these Bylaws. The Director, based on recommendations from the Medical Executive Board, may consider membership for other licensed independent practitioners who are permitted by law to provide patient care service independently and who meet the qualifications, standards and requirements of VHA, MHVAHCS, and these Bylaws, Rules and Regulations.

2. Categories of the Medical Staff:

   a. Active Medical Staff consists of full-time and part-time, equal to or greater than 4/8 time, physicians, dentists, optometrists, podiatrists and doctoral-level psychologists, chiropractors, audiologists and speech language pathologists who are professionally responsible for specific patient care and/or education and/or research activities at MHVAHCS and who assume all the functions and responsibilities of membership on the active staff. They may hold faculty appointments in the school of their discipline. They will actively participate in quality improvement activities required of the staff. Members of the active medical staff are appointed to a specific, professional medical staff service and are eligible to serve and vote on medical staff committees. A member will

satisfy the requirements for attendance at meetings of the Medical Staff, the service, and committees they are assigned.

b. Associate Medical Staff shall consist of part-time, equal to or less than 3/8 time physicians, dentists, optometrists, podiatrists, doctoral-level psychologists, chiropractors, audiologists, and speech language pathologists, intermittent, consultants, telemedicine consultants, contract, fee for service, and without compensation (WOC) staff who complement the members of the active Medical Staff in their roles in patient care, education and research. Members of the associate Medical Staff are appointed to specific professional medical staff services. The associate staff members are not required but are eligible to serve and vote on Medical Staff committees. They may attend the meetings of the Medical Staff but cannot vote.

c. House Staff: The house staff shall consist of those individuals who are graduates of medical, osteopathic, optometry or podiatric schools, engaged in a formal program of postgraduate training and education at MHVAHCS with or without compensation. They are not included for the purposes of clinical privileges except as noted below. They will function only under the supervision of a licensed independent practitioner within the clinical privileges deemed appropriate by and granted to, a qualified practitioner who has clinical privileges in the area being supervised. However, they are expected to function in a manner which is consistent with these Medical Staff Bylaws, Rules and Regulations. Unless specifically included as a voting member, they will serve as ex-officio members on designated Medical Center committees. They may attend the meetings of the Medical Staff but cannot vote.

d. Affiliate Medical Staff: The non-physician staff affiliates shall consist of CRNAs, PAs, APRNs, CNSs, and board-certified clinical pharmacists who participate directly in the management of patients under the general supervision or direction of a staff physician. All PAs, CRNAs, APRNs, Clinical pharmacy specialists, and CNSs will be credentialed in accordance with VHA Handbook Credentialing and Privileging and VetPro (VHA's electronic credentialing databank). Non- physician staff affiliates function to provide care within their credentialed scope of practice and collaborative physician supervision as assigned and may be granted prescriptive authority when proper criterion is met. They may attend the meetings of the Medical Staff but cannot vote.

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

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

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

   a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required by VA employment and utilization policies and procedures, or limited, institutional state license expressly stating that the individual may practice at this healthcare system as per the exceptions listed for the full and unrestricted license requirements listed in VA Handbook 5005, Part II, Chapter 3, paragraph 4b. Failure to maintain at least one unrestricted license and/or involuntary termination of any license will result in automatic termination of the practitioner's clinical privileges and appointment to MHVAHCS. The licensure requirement for physician assistants may be waived if the appointment was initially approved prior to January 1, 2012, and there was no break in service.

   b. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine or equivalent (Bachelor of Medicine [MBBS]), Osteopathy, or Dentistry from an approved college or university.

   c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certifications, and other specialty training (see Medical Center Memorandum entitled, CARDIOPULMONARY RESUSCITATION AND LIFE SUPPORT TRAINING FOR STAFF).

   d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying, including recent privileges held. For new appointments to the medical staff, current competence is documented by recommendations from peers and supervisors, attesting to the applicant's ability to perform satisfactorily the privileges requested.

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

   f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VI or VII or of these Bylaws and the healthcare system policy on credentialing and privileging for a position for which MHVAHCS has a patient care need, and adequate facilities, support services and staff.

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

   h. English language proficiency must be demonstrated.

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

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

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

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

      i) Physicians

      ii) Dentists

      iii) Doctoral-level psychologists

      iv) Licensed Audiologists

      v) Licensed Speech Language pathologists

      vi) Chiropractors

      vii) Podiatrists

      viii) Optometrists

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

      i) Clinical Pharmacy Specialist

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

      i) Physician Assistants.

      ii) Advanced Practice Nurses

      iii) Certified Registered Nurse Anesthetist (CRNA)

      iv) Certified Registered Nurse Practitioner (CRNP)

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

Section 3.03 Code of Conduct

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

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

   Behavior or Behaviors That Undermine a Culture of Safety is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that Behavior or Behaviors That Undermine a Culture of Safety is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, Behavior or Behaviors That Undermine a Culture of Safety may reach a threshold such that it

constitutes grounds for further inquiry by the Medical Executive Board into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action.

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

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

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

Section 3.04 Conflict Resolution & Management

For VA to be effective and efficient in achieving its goals, the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA 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, Compliance Officer, or Chief, Quality Management Service.

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. Composition:

   a. Chief of Staff.

b. Deputy Chief of Staff.

c. Service Chiefs.

2. Qualifications: The Chief of Staff shall be board certified and meet all requirements for appointment to the medical staff. The Chief of Staff is not required to have clinical privileges.

3. Selection: The Network Director approves recommendations to the position of Chief of Staff. The selecting organization is responsible to complete and submit information on the selectee to the Leadership Management and Succession Sub- Committee (LMSS). The LMSS support staff (Executive Recruitment Team) in the Workforce Management and Consulting Office will submit templates to the Leadership Management and Succession Sub-Committee and Workforce Committee for information only.

4. Removal: All disciplinary and/or adverse actions involving a Chief of Staff position must be referred to the Office of the Accountability Review (OAR). The OAR Employee Relations division will assign an Employee Relations Specialist to work directly with the proposing and deciding officials.

5. Duties:

a. Chief of Staff serves as President of the Medical Staff for Joint Commission purposes and Chairperson of the Medical Executive Board and is fully responsible to the Director for programs of patient care and the educational and research activities of the clinical services. To carry out these responsibilities, the Chief of Staff:

i) Formulates and recommends plans for a comprehensive program of medical care.

ii) Develops the requirements of staff, facilities, equipment and supplies needed to carry forward such an integrated program, utilizing necessary reviews and controls.

iii) Collaborates with the Associate Director for Patient Care/Nursing Services in the formation and supervision of the clinical and administrative activities inherent in assigned services.

iv) Appraises the effectiveness of the various medical programs in meeting the needs of patient care.

b. The Deputy Chief of Staff is fully responsible to the Chief of Staff to provide oversight and leadership for the clinical, teaching and research functions. Specific assignments will reflect workforce development and succession precepts for potential and future advancement of clinical and research programs.

c. Service Chiefs provide counsel and assistance to the Chief of Staff, Deputy Chief of Staff and Director regarding all facets of patient care, treatment and services including evaluating and improving quality and safety of patient care services.

Section 4.02 Leadership

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

Section 4.03 Clinical Services

1. Characteristics:

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

   b. Clinical Services hold service-level meetings a minimum of ten (10) times per year. Minutes are recorded and maintained by the Service.

2. Functions:

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

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

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

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

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

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

   g. Annually review privilege templates for each Service and make recommendations to Medical Executive Board.

3. Selection and Appointment of Service Chiefs: Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff and with the endorsement of the respective VISN 9 and VHA Program Directors.

a. Service Chiefs shall be board certified by the appropriate specialty board or possess comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. They are appointed by the Director, based upon the recommendation of the Chief of Staff, and approved by the VISN 9 Executive Resource Board, and, if appropriate, the VHA Headquarters Program Director.

b. Service Chiefs who are not a physician or dentist will be assisted by a Senior Physician or Dentist who must meet qualifications established by the Credentialing Committee.

c. Board certified, if applicable, in the clinical specialty area in which they will practice is preferred as an objective indication of clinical skill and a measure of quality in the delivery of patient care. Physicians who are not board certified or eligible for board certification may be appointed as outlined in VHA Handbook 1100-19, Credentialing and Privileging. Clinical Service Chiefs should be board certified, if applicable, by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty not appropriate for the assignment, the Credentialing Committee affirmatively establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. Appointment of service chiefs without board certification will comply with the VHA policy for these appointments as appropriate (Element 36 – Qualifications).

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

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

b. Clinically related activities of the Service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.
2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.
3. The presence of fifty one (51) percent of a committee's members will constitute a quorum.
4. The members of all standing committees, other than the Medical Executive Board, are appointed by the Chief of Staff subject to approval by the Medical Executive Board, unless otherwise stated in these Bylaws.

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

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

Section 5.02 Executive Committee of the Medical Staff

1. Characteristics: The Medical Executive Board serves as the Executive Committee of the Medical Staff. The members of the Medical Executive Board:

   a. The membership, and their individual roles and responsibilities, of the Medical Executive Board will be comprised of staff of the MHVAHCS as designate by Medical Center Memorandum entitled, MEDICAL EXECUTIVE BOARD.

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

   c. Selection process for membership: Members of the Medical Executive Board shall be an employee of good standing.

   d. Removal process for membership: Proposals by the medical staff to remove a member of the Medical Executive Board, including the Chair or Vice-Chair, will be directed to, and coordinated through, the Medical Center Director.

2. Functions of the Medical Executive Board: The Medical Executive Board:

   a. Acts on behalf of the Medical Staff between Medical Staff meetings within the scope of its responsibilities as defined by the Organized Medical Staff. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process in support of clinical privileges and/or scope of practice requested; to address the scope and quality of services provided within the facility.

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

   c. Makes recommendations directly to the Director regarding the:

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

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

      iii) Delineation of privileges for each Practitioner credentialed.

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

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

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

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

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

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

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

k. 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.

l. Acts upon recommendations from the Credentialing Committee.

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

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

o. Annually reviews and makes recommendations for approval of the Service- specific privilege lists.

3. Meetings:

a. Regular Meetings: Regular meetings of the Medical Executive Board shall be held. 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 Medical Executive Board 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 Medical Executive Board.

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

c. Meeting Notice: All Medical Executive Board members shall be provided at least ten calendar (10) days 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 Medical Executive Board. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to board meetings.

e. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the Medical Executive Board shall be fifty one (51) percent of the voting members of the board, 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 allopathic or osteopathic physicians.

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

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

Section 5.03 Committees of the Medical Staff

1. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Advance Practice Professionals and Associated health Practitioners (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners and (g) for such additional purposes as may be set forth in the charges to each committee:

a. Quality Executive Board:

i) Charge: (a) participate in developing and implementing an integrated interdisciplinary Facility-wide program to monitor the quality and safety of patient care and to promote an effective and efficient utilization of manpower, facilities and services; (b) facilitate mechanisms for correction of problems identified; (c) review the performance monitoring activities of the Continuous Readiness, Documentation and Standards, Disruptive Behavior, Utilization Management, and Systems Redesign Committees; (d) assist all Facility Services and Departments in identifying and evaluating problems in ancillary service utilization and encourage solutions which enhance quality of care; (e) fulfill the review requirements of The Joint Commission, and other external reviewing organizations; (f) report to the Chief of Staff, Medical Executive

Board, and Director pertinent issues concerning the quality control and performance improvement efforts.

ii) The membership, and their individual roles and responsibilities, of the Quality Executive Board will be comprised of staff of the MHVAHCS as designated by Medical Center Memorandum entitled, QUALITY EXECUTIVE BOARD.

iii) The frequency of meetings will be in accordance with Medical Center Memorandum entitled, QUALITY EXECUTIVE BOARD.

b. Credentialing Committee:

i) Charge: Review applications for appointment to the Medical Staff referred to it by the Chief of Staff or his designee(s); review the recommendations of the Chief of Staff and Service Chiefs; conduct personal interviews of candidates at its discretion; conduct a personal interview with the Chief of Staff and/or Service Chief in all instances of disapproval of an application by the Chief of Staff and/or Service Chief or both. In the event of the intent of the Committee to recommend disapproval, personal interviews shall be held with the Chief of Staff and Service Chief, if appropriate and with the candidate after written notification to the candidate of the intended disapproval. Between re-credentialing cycles, review the status and appropriateness of clinical privileges when cases are referred by the Chief of Staff or Service Chief. At the request of the Chief of Staff, review new/proposed changes to delineation of clinical privileges form(s); recommend appropriate action to the Credentialing Committee or Medical Executive Board.

ii) The membership, and their individual roles and responsibilities, of the Credentialing Committee will be comprised of staff of the MHVAHCS as designated by Clinical Memorandum entitled, CREDENTIALING & PRIVILEGING.

iii) The frequency of meetings will be in accordance with Clinical Memorandum entitled, CREDENTIALING & PRIVILEGING.

c. Special Care Committee:

i) Charge: The Special Care Committee will discuss and evaluate quality of care issues that pertain to the Special Care Areas of this medical center, i.e., ICU, PCU, and ED. (Based upon reviews conducted to assess the quality of patient care delivered in these units, the committee will make recommendations to improve operations and resource utilization.) The committee is responsible for the monitoring of cardiopulmonary resuscitation (CPR) activities. The Special Care Committee will review each episode of resuscitative care and related records, and the outcome and evaluate for appropriateness, process, and outcomes as part of continuous quality improvement.

ii) The membership, and their individual roles and responsibilities, of the Special Care Committee will be comprised of staff of the MHVAHCS as designated by Clinical Memorandum entitled, SPECIAL CARE COMMITTEE.

iii) The frequency of meetings will be in accordance with Clinical Memorandum entitled, SPECIAL CARE COMMITTEE.

d. Pharmacy and Therapeutics Committee:

i) 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 Facility for complete current information on matters related to pharmaceuticals and current pharmaceutical practices.

ii) The membership, and their individual roles and responsibilities, of the Pharmacy and Therapeutics Committee will be comprised of staff of the MHVAHCS as designated by Clinical Memorandum entitled, PHARMACY AND THERAPEUTICS COMMITTEE.

iii) The frequency of meetings will be in accordance with Clinical Memorandum entitled, PHARMACY AND THERAPEUTICS COMMITTEE.

e. Peer Review Committee:

i) Charge: Provide consistent, systematic, confidential, and timely protected peer review to ensure quality care is given by health care professionals. Peer review is intended to contribute to quality improvement efforts or resource utilization issues related to an individual provider in a non-punitive manner. Organizational issues may and should be identified with suggested actions for improvements, but the primary purpose of protected peer review is to improve the care provided to Veterans through review of individual health care professional decisions and act proactively to contribute to the best possible outcomes for our patients

ii) The membership, and their individual roles and responsibilities, of the Peer Review Committee will be comprised of staff of the MHVAHCS as designated by Clinical Memorandum entitled, PEER REVIEW FOR QUALITY MANAGEMENT.

iii) The frequency of meetings will be in accordance with Clinical Memorandum entitled, PEER REVIEW FOR QUALITY MANAGEMENT.

f. Infection Control Committee:

i) Charge: Define, survey, correlate, review, evaluate, revise and institute whatever recommendations are necessary in order to prevent, contain, investigate and control nosocomial infections and other infectious diseases among patients and personnel; submit committee minutes to the Medical Executive Board quarterly; and report a summary of its activities to the Medical Executive Board.

ii) The membership, and their individual roles and responsibilities, of the Infection Control Committee will be comprised of staff of the MHVAHCS as designated by Medical Center Memorandum entitled, MEDICAL CENTER INFECTION CONTROL PROGRAM.

iii) The frequency of meetings will be in accordance with Medical Center Memorandum entitled, MEDICAL CENTER INFECTION CONTROL PROGRAM.

g. Operative & Other Invasive Procedures Committee:

i) Charge: Operative & Other Invasive Procedures Committee serves as a cross functional interdisciplinary team to provide clinical oversight over quality assurance mechanisms and performance measurement concerning invasive procedures and peri-procedural services.

ii) The membership, and their individual roles and responsibilities, of the Operative & Other Invasive Procedures Committee will be comprised of staff of the MHVAHCS as designated by Clinical Memorandum entitled, OPERATIVE & OTHER INVASIVE PROCEDURES COMMITTEE.

iii) The frequency of meetings will be in accordance with Clinical Memorandum entitled, OPERATIVE & OTHER PROCEDURES COMMITTEE.

h. Documentation and Standards Committee:

i) Charge: This committee will direct and appraise the quality of the medical records to ensure their maintenance at a standard acceptable to the Joint Commission, the American Medical Association Council on Education, and VA Central Office. The committee will also be responsible for the surveillance and control of use of all medical record forms, medical records, and medical record data. In addition, the committee is responsible for ensuring that medical records protect both the medical and legal interests of the patient, medical center, and staff responsible for the patient.

ii) The membership, and their individual roles and responsibilities, of the Document and Standards Committee will be comprised of staff of the MHVAHCS as designated by Clinical Memorandum entitled, DOCUMENTATION AND STANDARDS COMMITTEE.

iii) The frequency of meetings will be in accordance with Clinical Memorandum entitled, DOCUMENTATION AND STANDARDS COMMITTEE.

i. Mental Health Executive Council:

i) Charge: The Mental Health Executive Council reviews and makes recommendations regarding plans that ensure an effective mental health service delivery system utilizing best practices and evidence-based interventions to promote the highest quality of mental health care. These plans include measurable goals and actions with identified responsibilities, resources and timelines. The Council ensures that needs of the Veterans and their families are met, serves as a problem-solving body and proposes strategies to improve care.

ii) The membership, and their individual roles and responsibilities, of the Mental Health Council will be comprised of staff of the MHVAHCS as designated by Clinical Memorandum entitled, MENTAL HEALTH EXECUTIVE COUNCIL.

iii) The frequency of meeting will be in accordance with Clinical Memorandum entitled, MENTAL HEALTH EXECUTIVE COUNCIL.

j. Research and Development:

i) Charge: The Research and Development Committee serves in an advisory capacity to the Director, through the Chief of Staff, on all professional and administrative aspects of Basic Laboratory Research, Clinical Sciences Research, Health Services Research, and the Rehabilitation Research Programs. The committee is responsible for ensuring the scientific and ethical quality of VA research, protection of human subjects in research, safety of personnel engaged in research, welfare of laboratory animals, security of VA data, and security of VHA research laboratories.

ii) The membership, and their individual roles and responsibilities, of the Research and Development Committee will be comprised of staff of the MHVAHCS as designated by Medical Center Memorandum entitled, RESEARCH & DEVELOPMENT COMMITTEE.

iii) The frequency of meetings will be in accordance with Medical Center Memorandum entitled, RESEARCH & DEVELOPMENT COMMITTEE.

2. Information Flow to Medical Executive Board: All Medical Staff Committees, including but not limited to those listed above, will submit minutes of all meetings to the Medical Executive Board in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the Medical Executive Board.

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, at a minimum on a quarterly basis.

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

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

Section 5.05 Establishment of Committees

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

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

ARTICLE VI. MEDICAL STAFF MEETINGS

1. Regular Meetings: Regular meetings of the Medical Staff shall be held on a quarterly basis. A record of attendance shall be kept.

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

3. Quorum: For purposes of Medical Staff business, 25% of the total membership of the medical staff membership entitled to vote constitutes a quorum. All Active Medical Staff employed 4/8 full-time equivalent (FTE) or greater are entitled to vote (see Section 3.01, Eligibility for Membership on the Medical Staff, item 2).

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. Independent Entity: MHVAHCS is an independent entity granting privileges to the medical staff through the Medical Executive Board and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Advanced Practice Professional, and Associated Health Practitioner reappointments may not exceed two (2) years, minus one day from the date of last appointment or reappointment date. Medical Staff and Advanced Practice Professionals and Associated Health Practitioners must practice under their privileges or scope of practice.

2. Credentials Review: All Licensed Independent Practitioners (LIP), and all Advanced Practice Professionals and Associated Health Practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. All Advanced Practice Professionals and Associated Health Practitioners will be subjected to full credentials review at the time of initial appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a period not to exceed two (2) years.

3. Deployment/Activation Status:

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

b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the Medical Executive Board for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Medical Executive Board to put a Focused Professional Practice Evaluation (FPPE) in place to support current competence. The Director has final approval for restoring privileges to active and current status.

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

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

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

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

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

5. Initial Focused Professional Practice Evaluation:

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

i) Criteria for conducting performance monitoring.

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

iii) Method for determining the duration of the performance monitoring.

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

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

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

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

iii) FPPE after Initial Appointment (see Section 7.04 Credentials Evaluation and Maintenance, item 4)

7. Ongoing Professional Practice Evaluation:

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

i) Ongoing professional practice evaluation results are reported semi- annually through the Credentialing Committee to the Medical Executive Board.

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

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

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

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

Section 7.02 Application Procedures

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

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

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

      ii) Education.

      iii) Relevant training and/or experience.

      iv) Current professional competence and conduct.

      v) Physical and Mental health status.

      vi) English language proficiency.

vii) Professional liability insurance (contractors only).

viii) Proof of current BLS certification using criteria established by the American Heart Association or an approved alternative is required for all onsite practitioners at the time of initial credentialing. See MHVAHCS Memorandum CARDIOPULMONARY RESUSCITATION AND LIFE SUPPORT TRAINING FOR STAFF for further categories of providers who require current BLS, ACLS, and ATLS training due to assignment and specific functions or areas of the facility. .

ix) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and will acknowledge that they have received a copy of the facility policy "Moderate and Deep Sedation" and agree to the guidelines outlined in the policy. Completion of assigned computer-based learning and maintenance of BLS and ACLS (ATLS for Emergency Department non-Emergency Medicine board certified provider) is required.

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

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

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

i) Name of health care institution or practice.

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

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

e. DEA/CDS Registration: A description of:

i) Status, either current or inactive.

ii) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, the Practitioner's Drug Enforcement Agency (DEA)/Controlled Dangerous Substances (CDS) registration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 7.03 Process and Terms of Appointment

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

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

3. Medical Executive Board Recommendation: The Medical Executive Board recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

4. Director Action: Recommended appointments to the Medical Staff should be acted upon by the Director within 30 calendar days of receipt of a fully complete

application, including all required verifications, references and recommendations from the appropriate Service Chief and the Medical Executive Board.

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

Section 7.04 Credentials Evaluation and Maintenance

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

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

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

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

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

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

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

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

   i) Criteria for conducting the FPPE.

   ii) Method for monitoring for specifics of requested privilege.

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

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

e. If at any time the Service Chief or designee cannot determine the competence of the Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:

   i) Extension of FPPE review period.

   ii) Modification of FPPE criteria.

   iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner).

   iv) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported).

Section 7.05 Local/VISN-Level Compensation Panels

Local 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 a Professional Standards Board require a separate review for a pay recommendation by the appropriate Compensation Panel.

ARTICLE VIII. CLINICAL PRIVILEGES

Section 8.01 General Provisions

1. Clinical privileges are granted for a period of no more than 2 years.

2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.

   a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.

   b. Reappraisal requires documentation of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements. Evidence of formal documentation may be requested of the provider.

c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Medical Executive Board. The verification date of a time- limited credential cannot be more than 120 days prior to the effective date of the privileges (VHA Handbook 1100.19 Credentialing and Privileging).

3. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Service Chief

4. Associated Health and Advanced Practice Professionals who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.

5. Requirements and processes for requesting and granting privileges are the same for all Practitioners who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.

6. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all Service Chiefs must recommend the practice.

7. Exercise of clinical privileges within any Service is subject to the rules of that Service and to the authority of that Service Chief.

8. When certain clinical privileges are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.

9. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

10. Tele-consultation: All Practitioners providing tele-consultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents

needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.

2. Requests in Writing: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.

3. Credentialing Application: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:

   a. Complete appointment information as outlined in Article VI, Section 7.02.

   b. Application for clinical privileges as outlined in this Article.

   c. Evidence of professional training and experience in support of privileges requested.

   d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Medical Executive Board.

   e. A statement of the current status of all licenses and certifications held.

   f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

   g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.

   h. Names and addresses of three (3) references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

   i. Evidence of successful completion of an approved BLS program meeting or using 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.

5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that he/she has received a copy of the facility Moderate and Deep Sedation policy and agree to the guidelines outlined in the

policy. Completion of the appropriate computer-based learning modules and ACLS and BLS certification are also required (ATLS required for Emergency Department providers who are not board certified in Emergency Medicine). Emergency Department practitioners are the only providers outside of the operating room who may perform rapid sequence intubation (RSI) using Etomidate. To qualify for this privilege, the Practitioners must meet the requirements for airway management.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:

   a. An application for clinical privileges as outlined in Section 8.02 of this Article. This includes submission of the electronic re-credentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.

   b. Supporting documentation of professional training and/or experience not previously submitted.

   c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Medical Executive Board.

   d. Documentation of continuing medical education related to area and scope of clinical privileges consistent with minimum state licensure requirements not previously submitted.

   e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.

   f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

   g. Names and addresses of two (2) peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

   h. Names of other hospitals or facility at which privileges are held and requests for copies of current privileges held.

2. Verification: Before granting subsequent clinical privileges, the Credentialing and Privileging Office will ensure that the following information is on file and verified with primary sources, as applicable:

   a. Current and previously held licenses in all states.

   b. Current and previously held DEA/State CDS registration.

   c. NPDB- Continuous Query Registration.

   d. FSMB query

   e. Physical and mental health status information from applicant.

   f. Physical and mental health status confirmation.

   g. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and FPPE.

   h. Continuous education to meet any local requirements for privileges requested.

   i. Board certifications, if applicable.

   j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Chief. This request will initiate the re-credentialing process as noted in the VHA Handbook 1100.19.

2. Primary source verification is conducted if applicable, e.g. provider attests to additional training.

3. Current NPDB Continuous Query Registration prior to rendering a decision.

4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Medical Executive Board followed by the Director's/Governing Body's approval.

Section 8.05 Recommendations and Approval for Initial/Renewal, Modification/Revision of Clinical Privileges

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.

2. The Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.

   a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience,

references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment.
The core competencies are:

i) Medical/Clinical Knowledge.

ii) Interpersonal and Communication skills.

iii) Professionalism.

iv) Patient Care.

v) Practice-based Learning & Improvement.

vi) System-based Practice.

b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE.

3. The Medical Executive Board recommends granting clinical privileges to the Director based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. The Credentialing Committee, a subcommittee of the Medical Executive Board, can make the initial review and recommendation but this information must be reviewed and approved by the Medical Executive Board.

4. Clinical privileges are acted upon by the Director within 30 calendar days of receipt of the Medical Executive Board recommendation to appoint. The Director's action must be verified with an original signature.

5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. The practitioner is provided with a copy of the approved privileges. These privileges are readily available through computer access to the appropriate staff for comparison with practitioner procedural and prescribing practice.

6. The Credentialing Committee recommends scopes of practice for practitioners with prescribing authority for concurrence to the Medical Executive Board for approval by the Director.

7. Renewal of clinical privileges shall also be based upon:

a. Physical and mental health status as it relates to practitioner's ability to function within privileges requested including such reasonable evidence of health status that may be required by the Professional Assistance Board.

b. Supporting documentation of professional training and/or experience not previously submitted.

c. Documentation of a minimum of 40 hours of continuing education every two years related to area and scope of clinical privileges, not previously submitted.

d. Status of all licenses, certifications held.

e. Any sanction(s) by a hospital, state licensing agency or any other professional health care organization; voluntary or involuntary relinquishment of licensure or registration; any malpractice claims, suits, or settlements (including those pending outcomes); reduction or loss of privileges at any other hospital.

f. Compliance to all other provisions of these Bylaws.

8. Verification

a. Initial privilege verification will be accomplished as described in Section 8.02 of this Article.

b. Re-privileging verification will be accomplished by primary source confirmation of the following as applicable:

i) All current licensure registrations at the time of appointment and initial granting of clinical privileges, at reappointment, renewal, or revision of clinical privileges, and at the time of expiration.

ii) Current DEA certification.

iii) Proactive Disclosure Service, NPDB-HIPDB, and Federation of State Medical Board queries.

iv) Board Certification obtained within the last two (2) years.

8. The renewal of clinical privileges process also includes the updating of information maintained in VetPro.

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 Director or Acting Director on the recommendation of the Chief of Staff.

a. Temporary privileges are based on verification of the following:

i) One, active, current, unrestricted license with no previous or pending actions.

ii) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.

iii) Current comparable clinical privileges at another institution.

iv) Response from NPDB Continuous Query registration with no match.

v) Response from FSMB with no reports.

vi) No current or previously successful challenges to licensure.

vii) No history of involuntary termination of medical staff membership at another organization.

viii) No voluntary limitation, reduction, denial, or loss of clinical privileges.

ix) No final judgment adverse to the applicant in a professional liability action.

b. A completed application must be submitted within three (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:

i) Verifies education and training;

ii) Verifies one active, current, unrestricted license from a State, Territory, or Commonwealth of the United States or the District of Columbia;

iii) Receives confirmation on the declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;

iv) Queries licensure history through the Federation of State Medical Boards (FSMB) Physician Data Center and receives a response with no report documented;

v) Receives confirmation from two (2) 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.

vi) Verifies current comparable privileges held in another institution; and

vii) Receives a response from NPDB Continuous Query registration with no match.

viii) Verifies that there are no current or previously successful challenges to licensure.

ix) Verifies that there is no history of involuntary termination of medical staff membership at another organization.

x) Verifies that there is no history of voluntary limitation, reduction, denial, or loss of clinical privileges.

xi) Verifies that there is no history of final judgments adverse to the applicant in a professional liability action.

c. A delegated subcommittee of the Medical Executive Board, 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 Board must be acted upon by the Medical Center 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 Board 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. The Director will declare approval for disaster privileges, when the situation is described as exceeding the capabilities of the MHVAHCS and/or the medical staff, and the Emergency Management Plan has been activated.

b. Disaster privileges are designed for a specified period under which health care professionals may practice on these disaster privileges. This period may not exceed ten (10) calendar days or the length of the declared disaster, whichever is shorter. At the end of this period, the practitioner needs to be converted to Temporary Privileges, as defined by in VA Handbook 1100.19 Credentialing and Privileging or be relieved. The integrity of two parts of the usual credentialing and privileging process must be maintained: 1. Verification of licensure and, 2. Oversight of care, treatment and service provided. The following process will be followed:

i) The Director, the Chief of Staff, or their designee, will be responsible for granting disaster privileges on a case by case basis at their discretion, after reviewing the Disaster Practitioner Identification Sheet, Disaster Privileges Form, and the Application for Disaster Credentialing located in Clinical Memorandum, CREDENTIALING AND PRIVILEGING.

ii) Providers will report to the Human Resource pool to present their credentials. The Medical Staff Coordinator will complete the Disaster Practitioner Identification Sheet, located in Clinical Memorandum, CREDENTIALING AND PRIVILEGING, and make photocopies for the practitioner file. Positive identification will be at a minimum from a valid government-issued photo

identification issued by a state or Federal agency (e.g., driver's license or passport) and at least one of the following:

(1) Current picture hospital ID card that clearly identifies the professional designation;

(2) Current state license to practice in any state;

(3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps, The Emergency System for Advance Registration-Volunteer Health Professional, or other recognized state or federal organization or group;

(4) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);

(5) Presentation by current hospital or medical staff members with personal knowledge regarding practitioner's identity and the volunteer's ability to act as a licensed independent practitioner during a disaster.

c. Practitioners will be required to complete the Disaster Privileges Form, and the Application for Disaster Credentialing Form. Verifications will be completed as soon as possible, depending on capabilities and resources. License and certification verification, work history, FSMB, OIG, and NPDB-PDS queries should be the first priorities and completed as soon as possible.

d. The Director or Chief of Staff will be provided the above information, along with any information that was verified for approval. The Director, Chief of Staff, or designee will approve privileges in writing.

e. Disaster providers will be issued a name tag from the Credentialing and Privileging Office that identifies them as Disaster Provider Volunteers and annotates their profession.

f. The Medical Staff Coordinator will notify the Director or Chief of Staff of any irregularities; any negative reports will be immediately investigated and may result in termination of the practitioner’s privileges.

g. The Service Chiefs will assign practitioners to a medical staff member, in the same specialty if possible, with whom to collaborate in the care of disaster victims and will provide direct observation and/or mentoring. If this is not possible, a retrospective clinical record review will be conducted of the patients who were assigned to the volunteer practitioners.

h. The Director or Chief of Staff will make a decision (based upon information obtained regarding the professional practice of the volunteer), within 72 hours related to the continuation of the disaster privileges initially granted. Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer licensed independent practitioner presents themselves to the medical center, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival, due to extraordinary circumstances, the medical center documents all of the following:

i) Reason(s) it could not be performed within 72 hours of the practitioner's arrival;

ii) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services;

iii) Evidence of the hospital's attempt to perform primary source verification as soon as possible.

5. The quality of the care and service rendered by each volunteer Practitioner with Disaster Privileges must be evaluated at the end of 72 hours and a determination made as to whether or not the Practitioner will be permitted to continue providing services.

6. If due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours or the practitioner's arrival, it is performed as soon as possible. Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or service under the disaster privileges.

7. In an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a lifesaving measure or to prevent serious harm, regardless of their clinical privileges, provided that the care, treatment, and services provided are within the scope of the individual's license.

8. Inactivation of Privileges: The inactivation of privileges occurs when a Practitioner is not an actively practicing member of the medical staff for an extended period of time such as extended sick leave or sabbatical with or without clinical practice while on sabbatical.

a. When the Practitioner returns to the Facility, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be verified again. Inactivation of privileges may not be used as a substitute for

termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.

b. At the time of inactivation of privileges, including separation from the medical staff, the Director ensures that within seven (7) calendar days of the date of separation, information is received suggesting that Practitioner met generally accepted standards of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.

9. Deployment and Activation Privilege Status: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment.

a. Facility staff request that a Practitioner returning from active duty communicate with the Facility staff as soon as possible upon returning to the area.

b. After the electronic credentials file has been reopened for credentialing, the Practitioner must update the licensure information, health status, and professional activities while on active duty.

c. The credentials file must be brought to a verified status. If the Practitioner performed clinical work while on active duty, an attempt is made to confirm the type of duties, the Practitioner's physical and mental ability to perform these duties, and the quality of the work. This information must be documented.

d. The verified credentials, the Practitioner's request for returning the privileges to an Active Status, and the Service Chief's recommendation are presented to the Medical Executive Board for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the Medical Executive Board is documented and forwarded to the Director for recommendation and approval of restoring the Practitioner's privileges to Current and Active Status from Deployment and/or Activation Status.

e. In those instances when the Practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.

f. In those instances where the privileges lapsed during the call to active duty, the Practitioner needs to provide additional references for verification and Facility staff need to perform all verifications required for reappointment.

g. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief, must consider whether a request for modification of the privileges held prior to the call to active duty should be initiated on a short-term basis.

h. If the file cannot be brought to a verified status and the Practitioner's privileges restored by the Director, the Practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VetPro:

i) Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.

ii) Registration with the NPDB-HIPDB PDS with no match.

iii) A response from the FSMB with no match.

iv) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.

v) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

Section 8.07 Medical Assessment

A medical history and physical examination is completed within 30 days of admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The initial and the updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, a maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA and hospital policy.
The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.

ARTICLE IX. INVESTIGATION, SUMMARY SUSPENSION AND ACTION

Section 9.01

1. Concerns Identified: Whenever there are concerns that a Practitioner has demonstrated substandard care, professional (clinical) misconduct, or professional (clinical) incompetence, further information will be gathered to either confirm or refute the legitimacy of the concerns. The individual's immediate supervisor will typically be the individual responsible for conducting a preliminary review of the alleged clinical deficiencies to determine whether a comprehensive focused clinical care review or other administrative review is warranted. The Chief of the Practitioner's clinical service, the Chair of Medical Executive Board, the Chief of Staff or the Director may also initiate a preliminary fact-finding.

2. Documentation: Whenever a preliminary fact finding confirms a concern 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, further review of the concerns may result in a fact-finding, administrative investigation, or comprehensive focused clinical care review. These findings may result in an administrative action.

a. Material that is obtained as part of a protected performance improvement activity (i.e., 38 U.S.C. 5705) may not be used to support an administrative action although performance improvement data, such as that obtained as a result of an Ongoing Professional Practice Evaluation (OPPE) may trigger a more comprehensive review of the Practitioner's work.

b. Quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705. Therefore, if such information is necessary in order to conduct a review of the alleged professional deficiencies and any action resulting from the review, it must be developed through mechanisms independent of the performance improvement program, such as a fact-finding, a comprehensive focused clinical care review, an administrative investigation, etc.

3. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care due to the potential of imminent danger to the health and well-being of an individual, including the Practitioner, to summarily suspend all or a portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Director. The typical process to be followed in order to summarily suspend a Practitioner's privileges is as follows (for information about the Automatic Suspension of Privileges, see paragraph 6 below):

a. The Chief of Staff will make a recommendation to the Director that a summary suspension of all or part of the Practitioner's privileges be invoked because the failure to take such action may result in an imminent danger to the safety and welfare of an individual.

b. The Director will approve the request, if appropriate, and the Practitioner will be issued a notification letter that all or part of the Practitioner's clinical privileges are suspended and include the general reason that the action being taken. This notice will also include information in regards to the requirement to report the individual to the National Practitioner Data Bank (NPDB) if the Practitioner should retire or resign prior to the conclusion of the clinical review and any action resulting from those findings being imposed. (**NOTE:** Management's decision to take a Practitioner out of patient care or place a Practitioner in an authorized leave status due to patient care concerns will result in a summary suspension of clinical privileges being imposed as the underlying reason for such action is due to concerns about the imminent danger to the health or well- being of an individual, and a summary suspension of clinical privileges letter must be issued to the Practitioner immediately.)

c. Immediately upon the imposition of a summary suspension, the Service Chief or the Chief of Staff will ensure that alternate medical coverage for the Practitioner's patients is provided.

d. The written notification of summary suspension of clinical privileges affords the Practitioner of the opportunity to submit, within 14 calendar days from receipt of the summary suspension notification letter, a written response to the concerns identified within the letter.

e. Upon receipt of the Practitioner's written response, the Director will determine whether or not the summary suspension of privileges should continue to be imposed pending the outcome of the comprehensive clinical review and any further action imposed as a result of the review. If the decision is made to continue the summary suspension of privileges, the Practitioner's response to the identified issues will be shared with the individual(s) conducting the review of the clinical concerns.

4. Review Process:

a. When sufficient evidence exists, based on the preliminary fact finding, that a Practitioner may have demonstrated substandard care, professional misconduct or professional incompetence that impacts the Practitioner's ability to deliver safe, high quality patient care, the Chief of Staff will normally appoint one or more impartial clinical care reviewers to complete a comprehensive focused - clinical care review of the concerns(s) or issues(s).

b. The Chief of Staff will determine the appropriate methodology and membership for conducting a review. The individual(s) tasked with performing this review must conduct it in a fair and objective manner, and may be selected from the Practitioner's facility or another facility at the discretion of the Chief of Staff and/or Director.

c. If the Practitioner is not summarily suspended as indicated in paragraph 3 of this Article, the Practitioner will be issued a letter notifying the Practitioner that if he/she resigns or retires while the review is being conducted, the Practitioner may be reported to the National Practitioner Data Bank (NPDB).

d. The individual(s) who are conducting the comprehensive focused clinical care review have the discretion to meet with the Practitioner to discuss or explain the clinical care concerns. This meeting does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation initiated at the direction of the Chief of Staff is an administrative matter and not an adversarial Hearing. A record of such meeting is made and included with the reviewers' findings, conclusions and recommendations reported to the Medical Executive Board.

e. The comprehensive focused-clinical care review is typically completed within 30- calendar days but may be extended if circumstances warrant a longer review period. Documentation in support of an extension should be maintained, and the Practitioner should be notified on regular intervals of the status of the review and the Practitioner being investigated will be apprised of the extension.

f. The reviewer(s) may review any documentation needed to fully assess the issues (except for those exempt in paragraph 2 above) and/or interview witnesses, including the Practitioner, at their discretion.

g. The report of the comprehensive focused clinical care review will be made to the Medical Executive Board within 21 calendar days after the reviewers have completed the investigation. The Medical Executive Board will assess the results and make a recommendation to the Medical Center Director regarding the appropriate action to be taken. The Medical Executive Board has the discretion to meet with the Practitioner within ten (10) calendar days after receipt of the evidence to ask him/her questions about the findings before reaching a conclusion regarding their recommendations. The Medical Executive Board is not required to meet with the Practitioner, and if the Practitioner fails to meet with the Medical Executive Board within a reasonable period of time, which is typically 21 calendar days after the meeting is requested, the Medical Executive Board must submit its recommendation for action without the Practitioner's input. This proceeding does not constitute a hearing, and there is no entitlement to any procedural rules set forth in Article X of these Bylaws or any other VA regulations. The Medical Executive Board is not required to share the report or any supporting documentation in advance of the proceeding or during the proceeding with the Practitioner. A record of such proceedings will be made and included with the reviewers' findings, conclusions and recommendations that are submitted to the Director.

5. Recommendations Following the Review:

a. The Medical Executive Board can make the following recommendations to the Director based on the evidence gathered before, during and after the review:

i. No action;

ii. Initiation of a Focus Peer Performance Evaluation (FPPE);

iii. Revocation of privileges; or

iv. Reduction in privileges.

b. Within five (5) business days, the Director will review the recommendation of the Medical Executive Board, and forward it to the Chief of Staff for appropriate administrative action, if applicable.

c. No action: If the Director concurs with the Medical Executive Board's recommendation for no action, the Practitioner will be notified in writing within five calendar days and, if applicable, be notified that privileges are restored.

d. FPPE:

i. If the recommendation is for a FPPE to be initiated, privileges will be reinstated upon the creation and issuance of the FPPE. The FPPE will provide appropriate notification to the Practitioner of the areas of weakness and develop a plan under which the Practitioner can improve in order to successfully complete the FPPE and demonstrate the requisite skill and knowledge in those areas of clinical issues identified as a concern. (**NOTE:** A FPPE will normally be for a minimum of 60-calendar days. In general, extension of the FPPE is discouraged.)

ii. Upon completion of the FPPE, results will be reported back to the Medical Executive Board.

e. Revocation of Privileges:

i. If the Medical Executive Board recommends that the Practitioner's privileges be revoked, or if a Practitioner fails a FPPE and the Medical Executive Board subsequently recommends the revocation of privileges, the Chief of Staff will assess the evidence and coordinate the separation of the Practitioner with Human Resources Management Service, unless management offers the Practitioner a position at the facility that does not require the Practitioner to have clinical privileges.

ii. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed removal and proposed revocation of privileges in accordance with VA Handbook 5021, Part II, unless other separation procedures under VA Handbook 5021, Part VI are applicable. If the Practitioner is separated and the Practitioner's privileges are revoked for issues involving professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board, if applicable.

iii. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a)(1), the Director will issue a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of the right to a fair hearing after the separation is imposed in accordance with Article X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

iv. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the Practitioner may be assigned to duties that do not require a reduction in grade or basic pay or the procedures in VA Handbook 5021, Part III will be followed, unless other separation procedures under VA Handbook 5021, Part VI are applicable. (***NOTE:*** Probationary employees cannot be issued a major adverse action, and thus a suspension, transfer of function, reduction in grade or basic pay is not an option.) If the Practitioner is separated, he/she will be afforded the opportunity for a fair hearing after separation in accordance with Part X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

v. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for revocation of clinical and privileges

and need to remove the Practitioner from the facility. The Practitioner will be separated and subsequently be notified of the right to a fair hearing after separation in accordance with Article X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reappointment to the medical center

f. Reduction of Privileges:

i. If the Medical Executive Board recommends that the Practitioner's privileges be reduced, or if a Practitioner fails an FPPE and the Medical Executive Board subsequently recommends the reduction of privileges, the Chief of Staff will assess the evidence and coordinate the reduction of the Practitioner's privileges with Human Resources Management Service.

ii. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed reduction of privileges and proposed reduction in grade or basic pay in accordance with VA Handbook 5021, Part II, if the Practitioner's change in privileges will result in a reduction in grade or basic pay. If the Practitioner's grade or basic pay and privileges are reduced for issues involving professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board.

iii. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a)(1), the Director must determine if the Practitioner's services are still needed given the reduction in privileges.

a. If it is determined that the Practitioner's services are still needed, management will follow the procedures for modifying a Practitioner's privileges.

b. If the Practitioner's services are no longer needed, then the Practitioner will be issued a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of right to a fair hearing after separation in accordance with Article X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

iv. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the Practitioner may be assigned to duties that do not require a reduction in privileges or the procedures in VA Handbook 5021, Part III will be followed, unless other separation procedures under VA Handbook 5021, Part VI are applicable. (**NOTE:** Probationary employees

cannot be issued a major adverse action, and thus a suspension, transfer of function, reduction in grade or basic pay is not an option.) If the Practitioner is separated, he/she will be afforded the opportunity for a fair hearing after separation in accordance with Article of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

v. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for reduction of clinical and privileges. If the Practitioner's services are no longer needed, the Practitioner will be separated from the contract and subsequently be notified of the right to a fair hearing after separation in accordance with Article X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation from the contract is for substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. If it is determined that the Practitioner's services are still needed, management will notify the Practitioner of the right to a fair hearing of the reduction of clinical privileges in accordance with Article X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the reduction are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB.

6. Automatic Suspension of Privileges:

a. An automatic suspension of privileges occurs immediately under the occurrence of an event that may include, but is not limited to, the following:

i. The Practitioner is being investigated or was indicted for a misdemeanor or felony. The privileges may only be reinstated after the outcome of the legal issue is finalized and after a determination is made regarding the nexus between the legal issue and the mission of VA.

ii. The Practitioner is being investigated for conduct or behavior issues that do not have an impact on patient care but management has determined it could negatively impact the work environment.

iii. The Practitioner is being investigated for the fraudulent use of Government equipment or a Government-issued credit card.

iv. The Practitioner fails to maintain the mandatory requirements for membership to the Medical Staff.

b. Immediately upon the imposition of an automatic suspension, the Service Chief or the Chief of Staff will ensure that alternate medical coverage for the Practitioner's patients is provided.

c. The Director may initiate an appropriate review of the concern(s) or issues(s) resulting in the automatic suspension to include recommendations for appropriate administrative action.

d. If there are more than three automatic suspensions of privileges in one (1) calendar year, or more than 20 days of automatic suspension in one (1) calendar year, a thorough assessment of the need for the Practitioner's services must be performed, documented in writing, and appropriate action taken.

7. Actions Not Constituting Corrective Action: The comprehensive clinical care reviewers responsible for conducting reviews are not deemed to have proposed 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 under Article X or a Disciplinary Appeals Board (DAB) 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 a matter;

c. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview, conference, or proceeding 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 conducted prior to a proposed adverse recommendation or action;

d. The failure to obtain or maintain any 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 Practitioner be directed to obtain retraining, additional training, continued education, or placement on a FPPE; or

h. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.

ARTICLE X. FAIR HEARING AND APPELLATE REVIEW

Section 10.01 Reduction of Privileges

1. Reduction of Privileges:

a. Prior to any action or decision by the Director regarding reduction of privileges, that does not also involve a major adverse action, such as a

suspension, reduction in grade, or reduction in basic pay, as defined in VA Handbook 5021, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

i) A description of the reason(s) for the change.

ii) A statement of the Practitioner‘s right to be represented by counsel or a representative of the individual’s choice, throughout the proceedings.

b. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff’s written notice of intent and receipt of all evidence. The Practitioner must submit a response within ten (10) business days of the Chief of Staff’s written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed ten (10) additional business days except in extraordinary circumstances.

c. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the Practitioner disagrees with the Director’s decision, a hearing may be requested. The Practitioner must submit the request for a hearing within five (5) business days after receipt of decision of the Director.

d. A proposed action taken to reduce a Practitioner’s privileges will be made in accordance with VHA Handbook 1100.19. In instances where reduction of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code, the proposed reduction of privileges will be combined with a major adverse action (e.g. suspension, reduction in basic pay, reduction in grade, transfer, etc.) in accordance with Section 7461 7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations. ***NOTE:*** A major adverse action may not be proposed against a 38 U.S.C. Section 7403 or Section 7405 (except nurses) employee, or a contractor.

2. Convening a Panel:

a. A panel is not convened if a reduction in clinical privileges is combined with a major adverse action, such as a suspension, reduction in grade, or a reduction in basic pay, due to substandard care, professional misconduct or professional incompetence. A reduction in basic pay may occur when a physician’s salary is reduced by a pay panel as a result in a reduction in privileges. In those instances, the proposed reduction and proposed major adverse action are taken together in accordance with the provisions of VA Handbook 5021, Part II.

b. In the case of a reduction in clinical privileges that does not constitute a major adverse action or is not combined with a major adverse action in

accordance with VA Handbook 5021, the Director must appoint a review panel of at least three (3) unbiased professionals, within five (5) business days after receipt of the Practitioner's request for a hearing. These professionals will conduct a review and hearing. At least two (2) members of the panel must be members of the same profession. If specialized knowledge is required, at least one (1) member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

i. The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 business days and not more than 30 business days from the date of the notification letter.

ii. During such hearing, the Practitioner has the right to:

a) Be present throughout the evidentiary proceedings;

b) Be represented by an attorney or other representative of the Practitioner's choice. **NOTE:** If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses; and

c) Cross-examine witnesses.

NOTE: *The Practitioner has the right to purchase a copy of the transcript or tape of the hearing.*

3. The panel must complete the review and submit the report within 15 business days from the date of the close of the hearing. The panel may request in writing that the Director grant additional time due to extraordinary circumstances or cause.

a. The panel's report, including findings and recommendations, must be forwarded to the Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

b. The Director must issue a written decision within ten (10) business days of the date of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.

c. If the Practitioner wishes to appeal the Director's decision, the Practitioner may appeal to the appropriate VISN Director within five (5) business days of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

d. The VISN Director must provide a written decision, based on the record, within 20 business days after receipt of the Practitioner's appeal.

NOTE: *The decision of the VISN Director is not subject to further appeal.*

4. The hearing panel chair shall do the following:

a. Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.

c. Maintain decorum throughout the hearing.

d. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.

e. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.

f. Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.

g. Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

5. Practitioner's Rights:

a. The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, (provided that this representative does not have a conflict of

interest) cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

b. The Practitioner may submit a written appeal to the VISN Director within five (5) business days of receipt of the Director's decision, if he/she is in disagreement with the decision rendered.

c. If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, for greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

Section 10.02 Revocation of Privileges

6. Revocation of Privileges:

a. Proposed action taken to revoke a Practitioner's privileges will be made in accordance with VHA Handbook 1100.19, and the following regulations are applicable:

i) In instances where revocation of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations.

ii) For probationary employees appointed under 38 U.S.C. 7401(1) and part-time temporary registered nurses appointed under 38 U.S.C. 7405, the Professional Standards Board (PSB) will convene in accordance with the procedures outlined in VA Handbook 5021, Employee/Management Relations. If separation is recommended and the recommendation from the PSB is based in whole, or in part, for reasons of substandard care, professional incompetence, or professional misconduct, the Director, or designee, may separate the Practitioner as prescribed in VA Handbook 5021. Separation constitutes an automatic revocation of clinical privileges, which is reportable to the NPDB, if the Practitioner is a physician or dentist, but only after being afforded due process. All practitioners, whether reportable to the NPDB or not, are entitled to due process. Refer to Article X, Section 10.01, paragraph 2 for due process procedures.

iii) In instances where the Practitioner is appointed through a contract or other "at will" appointment, including but not limited to part-time (excluding part-time temporary registered nurses who are covered under the procedures in paragraph 5(a)(ii), fee basis, without

compensation, or intermittent appointment, separation may occur immediately, but separation constitutes an automatic revocation of clinical privileges and is reportable to the NPDB if the Practitioner is a physician or dentist, and the revocation is for substandard care, professional incompetence, or professional misconduct. A report to the NPDB may not be filed until all due process has been exhausted. Refer to Article X, Section 10.01, paragraph 2 for due process procedures.

b. Revocation procedures will be conducted in a timely fashion. Revocation of clinical privileges may not occur unless the Practitioner is also discharged, separated during probation, or the appointment is terminated. However, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB, if the Practitioner is a physician or dentist and the revocation of privileges and subsequent reassignment constitutes a major adverse action due to a reduction in grade or basic pay, is for reasons of substandard care, professional incompetence, or professional misconduct (e.g., a surgeon's privileges for surgery may be revoked, and the surgeon may be reassigned to a non- surgical area when doing so is beneficial to meeting other needs of the facility). Any recommendation by the Medical Executive Board for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X, section 10.01, paragraph 2 of these Bylaws.

7. Reporting to the National Practitioner Data Bank[1]:

a. Tort ("malpractice") claims are filed against the United States government, not individual Practitioners. There is no direct financial liability for named or involved Practitioners. Government attorneys (Regional Counsel, General Counsel), consider the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.

b. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioner should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.

c. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist Regional and General Counsel in defending the case and in decisions concerning denial or settlement.

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[1] Reference VHA Handbook 1100.17.

d. Post payment reviews are performed nationally by the office of Medical- Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff's case when a tort claim settlement is submitted for review.

e. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physicians and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR 46.4. The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. After the final action, the reduction or revocation, as well as the summary suspension if greater than 30 days, will be reported.

8. Reporting to State Licensing Boards: VA has a responsibility to report to state licensing boards appointed or suspended members of the Medical Staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

9. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non- patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405, may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

ARTICLE XI. RULES AND REGULATIONS

1. As may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to identify the level of clinical practice that is required of each member of the Medical Staff and of all others with delineated clinical privileges or practicing under a Scope of Practice, Medical Staff Rules and Regulations may be adopted. Rules and Regulations may be adopted, amended, repealed or added by a two-thirds majority vote of the members of the MHVAHCS Medical Executive Board present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. Medical Staff Rules and Regulations must be approved by the Director.

ARTICLE XII. AMENDMENTS

1. These Bylaws are reviewed at least every two (2) 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 these Bylaws may be submitted in writing to the Medical Executive Board by any member of the Medical Staff. Recommendations for change come directly from the Medical Executive Board. Changes to the bylaws are amended, adopted and voted on by the Organized Medical Staff as a whole and then approved by the Director. The Bylaws are amended and adopted by two-thirds endorsement of the active medical staff.

2. The Medical Executive Board may provisionally adopt and the Director may provisionally approve urgent amendments to the Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the medical staff. After adoption, these urgent amendments to the Rules and Regulations will be immediately communicated back to the Organized Medical Staff for retrospective review and comment on the provisional amendment. Proposed significant changes may be submitted in writing to the Chief of Staff by any Service Chief or member of the Medical Staff. Changes will be coordinated by the Chief of Staff and a written text will be distributed to all members of the medical staff for review. A period of not less than ten (10) working days will be allowed for receipt of written comments from the staff on proposed changes. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.04, of these Bylaws should be followed.

3. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.

4. All changes to these Bylaws require action by both the Organized Medical Staff and the Director. Neither may unilaterally amend these Bylaws.

5. Changes are effective when approved by the Director.

ARTICLE XIII. ADOPTION

These Bylaws, Rules and Regulations shall be adopted upon recommendation of the voting members of the Organized Medical Staff at which a quorum of 25% of the voting members of the Organized Medical Staff are present or the conditions specified for an e-meeting/vote are met. They shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Director.

If the voting members of the Organized Medical Staff propose to adopt a rule, regulation, or policy or an amendment thereto, they must first communicate the proposal to the Medical Executive Board. If the Medical Executive Board proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the

proposal to the Medical Staff When the Medical Executive Board adopts a policy or amendment thereto, it must communicate this to the Medical Staff

Adopted by the Medical Staff, Mountain Home VA Healthcare System, Mountain Home, Tennessee, this 30th Day of September 2015.

RECOMMENDED:

David S. Hecht, MD, MBA Date 10/02/15

Chief of Staff

APPROVED:

Charlene S. Ehret, FACHE Date 11-25-15

Director

MEDICAL STAFF RULES AND REGULATIONS

1. GENERAL

a. The Rules relate to role and/or responsibility of members of the Medical Staff and individuals with clinical privileges in the care of any and all patients.

b. Rules of Departments or Services will not conflict with each other, rules and policies of the Medical Staff, or with requirements of the Governing Body.

c. The Medical Staff as a whole shall hold meetings at least quarterly.

d. The Medical Executive Board serves as the executive committee of the Medical Staff and between the quarterly meetings, acts in their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.

e. Each of the clinical Services shall conduct meetings monthly and not less than ten (10) meetings per year to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by medical staff and responsible party of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.

f. Information used in quality improvement as referenced in Article IX, cannot be used when making adverse privileging decisions.

2. PATIENT RIGHTS

a. Patient's Rights and Responsibilities: MHVAHCS supports the rights of each patient. MHVAHCS publishes policy and procedures to address rights including each of the following:

i) Reasonable response to requests and need for service within capacity, mission, laws and regulations.

ii) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.

iii) Collaboration with the physician in matters regarding personal health care.

iv) Pain management including assessment, treatment and education.

v) Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.

vi) Formulation of advance directives and appointment of surrogate to make health care decisions (38 CFR 17.32, Informed Consent and Advance Care Planning).

vii) Access to information necessary to make care decisions that reflect patient's wishes, including potential outcomes, risks and benefits and consequences of refusal of treatment.

viii) Access to information about patient rights, handling of patient complaints.

ix) Participation of patient or patient's representative in consideration of ethical decisions regarding care.

x) Access to information regarding any human experimentation or research/education projects affecting patient care.

xi) Personal privacy and confidentiality of information.

xii) Action by a legally authorized person to exercise a patient's rights if a patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or unable to communicate his/her wishes.

xiii) Authority of the Chief of Staff to approve/authorize necessary surgery, an invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available).

xiv) Foregoing or withdrawing life-sustaining treatment including resuscitation.

xv) Nondiscrimination against individuals who use or abuse alcohol or other or other illicit drugs and persons infected with the human immunodeficiency virus.

b. Living Will, Advance Directives, and Informed Consent (38 CFR 17.32)

i) Competent patients have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.

ii) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with, as appropriate, other members of the treatment team (38 U.S.C. 7331, Informed Consent).

iii) With respect to the documentation of decision making concerning life- sustaining treatment, the following information, at a minimum, will be documented in the progress notes by the attending physician: The patient's diagnosis and prognosis; an assessment of the patient's decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.

iv) Competent patients will be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning life-

sustaining treatment will be honored, and will be documented in the medical record.

v) Advance Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any competent patient may execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a declarant at any time.

vi) Substituted Judgments: The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:

(a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.

(b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.

(c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the attending physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's

own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body, or Chief of Staff.

3. RESPONSIBILITY FOR CARE

a. Conduct of Care

i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff. Patients shall be admitted in accordance with VA admission policies as stated by the Under Secretary for Health. Patients shall be admitted only on a written order of a physician or oral surgeon. This includes admissions for observation, whether converted to a full inpatient or discharged.

(a) The attending 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, provider's discharge instructions sheet, including condition on discharge (discharge note) and primary diagnosis, and discharge summary.

(b) A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA regulations and hospital policy. The content of complete and focused history and physical examination is delineated in this Section, Responsibility for Care, of these Medical Staff Rules and Regulations.

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

(c) The attending physician responsible for the patient must sign the admission note if it is prepared by a resident, intern, or Advanced Practice Professional, or make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" or make whatever comments he/she thinks the case warrants, or prepare a complete admission within forty eight (48) hours of admission to the Community Living Center. In the event a resident, intern, or Advanced Practice Professional prepares an admission workup, all will be retained, but the official workup will contain the responsible attending physician's approval signature. All resident documentation will follow procedures outlined in the VHA Handbook 1400.1, Resident Supervision.

(d) 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.

(e) 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.

(f) Progress notes will be written by the appropriate medical staff member at least once daily on all acutely ill patients. Progress notes are written for all patients seen for ambulatory care by the appropriate medical staff member and electronically signed within 24 hours.

(g) 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. 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.

(h) Upon determination that a Do Not Attempt Resuscitation order is appropriate, the order must be written or, rewritten by the attending

physician within a 24-hour period if the Do Not Attempt Resuscitation order was implemented by a resident. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a Do Not Attempt Resuscitation 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

(i) 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.

ii) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and across Departments and Services and between all staff members who have clinical privileges.

iii) There is to be a comparable level of quality of surgical and anesthesia care throughout the Facility.

b. Consultations:

i) Consultation: Except in an emergency, consultation with a qualified physician is desirable when in the judgment of the patient's physician:

(a) The patient is not a good risk for operation or treatment,

(b) The diagnosis is obscure, and/or

(c) There is doubt as to the best therapeutic measures to be utilized.

ii) Consultant: A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Executive Board and the Credentialing & Privileging Committee on the basis of an individual's training, experience, and competence.

iii) Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A written clinical opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

iv) Responsibility for Requesting Consultations: The patient's physician, through the Chiefs of Services, shall make certain that members of the staff do not fail in the matter of providing consultation as needed.

v) Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.

c. Discharge Planning: Discharge planning is initiated as early as a determination of need is made.

i) Discharge planning provides for continuity of care to meet identified needs.

ii) Discharge planning is documented in the medical record.

iii) Criteria for discharge are determined by the Multidisciplinary Treatment Team.

iv) Discharge plans, including patient/caregiver education, medications, medication reconciliation, treatment, follow-up, and patient agreement are documented in the medical record.

d. Discharge

i) Patients shall be discharged from the Facility only upon the written order of the physician and the discharge summary will be completed (signed) and available for review in Computerized Patient Record System within two (2) business days of discharge from inpatient settings and three (3) business days for CLC residents. At time of completing the final summary, the responsible member of the Medical Staff shall review the medical record to ensure that documents therein pertain to the patient and contain accurate data. The record shall be completed within thirty (30) days of the discharge of the patient. The physician or dentist shall complete his/her portion of the record within thirty (30) days, including authentication per VHA Handbook 1907.01 and The Joint Commission (TJC) requirements.

ii) Patients from Ambulatory Surgery/Procedure Unit can be discharged based upon order of Licensed Independent Practitioner familiar with the patient or when the Practitioner is not available, based on relevant medical staff approved criteria. The Practitioner's name is recorded in the patient's medical record.

e. Autopsy

i) Autopsy services are provided through a contractual agreement with East Tennessee State University Quillen College of Medicine. 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.

ii) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17.170. 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.

iii) 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.

iv) Autopsies are encouraged as per VHA policy.

v) VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in Clinical Memorandum entitled, REQUESTS FOR AUTOPSY. Those cases meeting criteria as Medical Examiner's cases per policy will be referred to the appropriate County Medical Examiner's Office in accordance with state statutes.

vi) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes.

f. Standard precautions will be vigorously enforced for preventing transmission of infectious diseases.

4. PHYSICIANS' ORDERS

a. General Requirements

i) Orders are entered into the Computerized Patient Record System.

ii) Verbal and telephone orders should be reserved for emergent/urgent situations where a delay would adversely affect patient care and when it is not reasonably possible for the provider to enter the order directly. Note: For the purposes of this policy and documentation in Computerized Patient Record System, a verbal order is one given in person and a telephone order is one communicated by telephone. In the event that an acute inpatient requires immediate advanced clinical assessment and evaluation, rapid assessment and prompt intervention, the Medical Emergency Team (MET) will be called.

iii) The following orders are never to be taken verbally:

(a) Discharge

(b) Anti-neoplastic medications

(c) Total Parenteral Nutrition

(d) Do Not Attempt Resuscitation

(e) Medication titration changes (as in Morphine Sulfate titration)

(f) Orders to withhold or withdraw life-sustaining procedures

(g) Hyperalimentation

(h) Prescription or administration of radiopharmaceutical medications

iv) Designated authorized personnel may accept emergent/urgent verbal/telephone orders. Exception: Authorized personnel may refuse verbal/telephone orders that, in their professional judgment, are unclear or of questionable safety.

v) Authorized personnel enter the orders into Computerized Patient Record System and "read back" entered orders to ordering practitioners to confirm. The authorized person entering the orders into Computerized Patient Record System releases the orders. A practitioner authenticates (signs) the verbal/telephone orders entered into the Computerized Patient Record System within 24 hours of order origination.

b. Medication Orders

i) All medications 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 Medications 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 medications" or "non-formulary medications" which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN level. Exceptions are based on an individual patient case by case basis.

ii) All medications used in the Facility will be stored and dispensed by the Pharmacy.

iii) All medication orders will be in accordance with the Medical Center Memorandum entitled, MEDICATION POLICY.

iv) Transfer of Patients: When a patient is transferred from one level of care to another level of care, or there is a change in physician of record, orders must be written for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.

c. Standardized Order Sets (protocols): Standardized order sets are reviewed periodically by Section or Service Chief and modified as needed. All

standardized order sets in the Computerized Patient Record System shall be authenticated by a Medical Staff member and are to be signed for each usage by the appropriate medical staff member. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief.

d. Investigational Medications: Investigational medications will be used only when approved by the appropriate Research & Development Committee and the Pharmacy and Therapeutics Committee and administered under approved protocol with patient informed consent, under the direct supervision and legitimate order of the authorized Principal Investigator or designated investigator.

e. Informed Consent

i) Informed consent will be consistent with legal requirements and ethical standards, as described in Clinical Memorandum entitled, INFORMED CONSENTS.

ii) Evidence of receipt of Informed Consent, documented in the medical record, is necessary in the medical record before procedures or treatment for which it is required.

f. Submission of Surgical Specimens: All tissues and objects removed at operation, shall be sent to the Facility pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis.

g. Special Treatment Procedures

i) DNAR (Do Not Attempt Resuscitation) 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 Memoranda, Medical Staff Bylaws, and these Rules.

ii) Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and may be utilized only within the guidelines of an established protocol in the Facility

policy related to Sedation/Analgesia and according to approved privileges. Only by those Practitioners with approved and current privileges to do so.

5. ROLE OF ATTENDING STAFF

a. Supervision of Residents and Non-Physicians

i) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities.

ii) Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment.

iii) Advanced Practice Professionals and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

b. Documentation of Supervision of Resident Physicians

i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.

ii) Entries in the medical record made by residents or those non-physicians (e.g., PAs, ARNPs, etc.) that require countersigning by supervisory or attending medical staff members are covered by appropriate Facility policy and include:

(a) Medical history and physical examination.

(b) Discharge Summary.

(c) Operative Reports.

(d) Medical orders that require co-signature.

(1) Do Not Attempt Resuscitation.

(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 the Computerized Patient Record System do not allow a second signature (co-signature), the attending

must either write the order for (1) through (5) above; or in an urgent/emergency situation, the house staff or non-physician must obtain verbal concurrence from the attending, document in the progress notes the discussion and concurrence, and can write and sign the order. The attending medical staff member must then co-sign the progress note noting the discussion and concurrence within 24 hours.)

iii) Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned graduated levels of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned graduated 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 attending physician over and above standard setting- specific documentation requirements (VHA Handbook 1400, Page 6, Supervision of Associated Health Trainees).

c. Designated administrative staff will be authorized to make administrative entries as approved by the Chief of Staff. These administrative entries can be for the purposes of: (1) creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering notes to disposition consultation requests and (5) completing other requirements as requested by the Chief of Staff or his/her designee.

6. MEDICAL RECORDS

a. Basic Administrative Requirements:

i) Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify the author; may include written signatures.

ii) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Advanced Practice Professionals.

iii) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in related Clinical Memorandum entitled, MEDICAL RECORD DOCUMENTATION, and is available in Computerized Patient Record System and Veterans Health Information Systems and Technology Architecture (VISTA). Those abbreviations are not acceptable for use either handwritten or in the Computerized Patient Record System.

iv) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.

v) Release of information is required per policy and standard operating procedures for the Facility.

vi) All medical records are confidential and the property of the Facility and shall not be removed from the premises without permission (Release of Information from the Patient/consultation with the Facility 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 by Medical Staff.

vii) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

b. All Medical Records must contain:

i) Patient identification (name, address, SSN, DOB, next of kin).

ii) Medical history including history and details of present illness/injury.

iii) Observations, including results of therapy.

iv) Diagnostic and therapeutic orders.

v) Reports of procedures, tests and their results.

vi) Progress notes.

vii) Consultation reports.

viii) Diagnostic impressions.

ix) Conclusions at termination of evaluation/treatment.

x) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in Facility Policy Memorandum "Informed Consent."

c. Inpatient Medical Records: In addition the items listed in section B above, all inpatient records must contain, at a minimum:

i) A history that includes chief complaint, history of present illnesses, childhood illnesses, adult illnesses, operations, injuries, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and illicit drugs), family history, chief complaint, and review of systems.

ii) A complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self- care, mentation, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient assessed personal history. Key examination medical impressions will be documented in the note. The note must be authenticated by the Practitioner at the earliest possible time, but always within 24 hours of being written in the Computerized Patient Record System.

(a) If the History and Physical was completed prior to the admission or procedure, it must be updated the day of admission. If it is more than 30 days old, a new one must be completed.

(b) Inpatient History and Physical must be completed within 24 hours, 48 hours for long term care; and seven (7) days for the Domiciliary

iii) A discharge plan (from any inpatient admission or Domiciliary), including condition on discharge.

iv) Have a discharge summary (signed) (from inpatient or Domiciliary) available for review in Computerized Patient Record System within two (2) business days from discharge for the inpatient setting and three (3) business days for Community Living Center residents.

v) Completed within 30 days of discharge.

d. Outpatient Medical Records: In addition the items listed in section B above, all outpatient records must contain, at a minimum:

i) A signed progress note for each visit.

ii) Relevant history of illness or injury and physical findings including vital signs.

iii) Patient disposition and instruction for follow-up care.

iv) Immunization status, as appropriate.

v) Allergies.

vi) Referrals and communications to other providers.

vii) List of significant past and current diagnoses, conditions, procedures, drug allergies.

viii) Medication reconciliation, problem, and any applicable procedure and operations on the Problem List.

e. Surgeries and Other Procedures:

i) All aspects of a surgical patient's care, including ambulatory surgery, pre- operative, operative and post-operative care, must be documented. Surgical interventions, diagnostic procedures, or other invasive procedures must be documented to the degree of specificity needed to support any associated coding data and to provide continuity of care.

ii) Preoperative Documentation:

(a) In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising or staff Practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed; discussion with

the patient and family of risks, benefits, potential complications; and alternatives to planned surgery and signed consent

(b) Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical or Subjective/Objective/Assessment/Plan (SOAP) note addressing pertinent positive/negative information, indications for the procedure, known risks related to the procedure, and a physical exam pertinent to the procedure. A formal consultation to the service for performing the procedure that includes all required content will serve as a History and Physical if completed 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 health record 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 the case of an emergency procedure at which time the Chief of Staff holds jurisdiction.

iii) Immediate Post-Operative Note: 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, blood loss and

(7) Complications.

(b) The immediate post-operative note may include other data items, such as:

(1) Anesthesia,

(2) Drains,

(3) Tourniquet Time, or

(4) Plan.

iv) 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. If the full operative report is not entered immediately, it shall be entered by midnight on the day of the procedure or no later than three (3) hours after surgery completion if the surgery is completed after 9 p.m. It is to be signed promptly by the surgeon and made a part of the patient's medical record. The body of the report needs to contain the: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative diagnosis; names of the supervising Practitioner, primary surgeon, and assistants; and the presence and/or involvement of the supervising Practitioner.

v) Post Anesthesia Care Unit (PACU) Documentation:

(a) PACU documentation must include the patient evaluation on admission to, and discharge from, the post-anesthesia care unit, a time-based record of vital signs and level of consciousness (either paper or electronic), all medications administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post- procedural complications, and post-anesthesia visits.

(b) The health record must document the name of the LIP responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.

(c) For inpatients, there needs to be at least one documented post- anesthesia visit after leaving the post-anesthesia care unit. The note needs to describe the presence or absence of anesthesia-related complications.

(d) For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery, to assess any complications, including anesthetic complications, as appropriate.

7. INFECTION CONTROL

a. Isolation is described in Medical Center Memorandum entitled, Medical Center Infection Control Program.

b. Standard Precautions are described in Medical Center Memorandum entitled, Medical Center Infection Control Program.

c. Reportable Cases are described in Medical Center Memorandum entitled, Medical Center Infection Control Program.

8. CONTINUING MEDICAL EDUCATION

a. All Medical Staff members shall participate in their own individual programs of Continuing Medical Education 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.

b. At initial credentialing and re-credentialing, all providers will attest to meeting their State Licensing Board (SLB) requirements for continued medical education. This will also include the minimum requirements placed by their particular SLB for controlled substance prescribing practices education (general a minimum of 2 hours).

9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

a. The VHA recognizes its responsibility to assist impaired Practitioners and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for the Practitioner.

b. Where there is evidence that a Practitioner's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Chief or Chief of Staff.

c. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the Tennessee Medical Foundation's Physicians Health Program for physicians and the Tennessee Professional Assistance Program for allied health professionals.

d. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable Facility policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational Health Program or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Professional Assistance Board.

e. 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.

f. Confidentiality of the Practitioner seeking referral or referred for assistance will be kept, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.

g. The Facility will sponsor periodic educational programs regarding illness and impairment issues. Licensed independent Practitioners will be issued written

information regarding illness issues at the time of initial appointment and re- appointment to the Medical Staff.

10. PEER REVIEW

a. All Medical Staff members shall participate in the facility protected peer review program established by the appropriate VHA policy.

b. All Medical Staff members will complete required training in accordance with the associated VHA policy

11. SMOKING POLICY

a. In accordance with the Veterans Health Administration (VHA) smoke-free policy, smoking or use of any tobacco product is prohibited inside medical center facilities and in Government-owned vehicles;

b. Because of the indisputable evidence that smoking and exposure to environmental tobacco smoke are detrimental to good health, it is the public policy position of VHA and medical center leadership that smoking is inconsistent with our responsibility for the treatment and prevention of illness. Patients, employees and the community will be advised, influenced and educated regarding the nature and magnitude of the health hazards of smoking and the use of smokeless tobacco products;

c. Smoking is also prohibited on contiguous facility grounds except in designated smoking shelters for staff, visitors and patients.

d. Patients, employees, volunteers, visitors or any other persons are not permitted to smoke, use, or display any tobacco product including cigarettes, electronic cigarettes, cigars, and pipes in any location within the medical center. This prohibition includes the display of unlit tobacco products and the use of smokeless tobacco products;

e. The distribution of free cigarettes or other tobacco products to patients is not permitted. In consideration of the addictive nature of nicotine and the difficulty of overcoming tobacco dependence, smoking cessation programs will be available for patients and employees: Medical Center Memorandums, TOBACCO/E-CIGARETTES USE POLICY and SMOKING FIRE HAZARD REDUCTION WHEN OXYGEN TREATMENT IS EXPECTED.

12. REQUIREMENTS FOR CPR CERTIFICATION (BLS OR ACLS)

All clinically active staff will have CPR education, whether through the AHA Basic Cardiac Life Support (BLS) for Healthcare Providers or through another similar program that includes both CPR and use of public access AED. In general all full-time, part-time, fee for service, and without compensation physicians and dentists will receive training and certification. Contract physicians should have BLS and/or ACLS training and certification specified in the contract. Service chiefs may identify consulting physicians requiring BLS/ACLS. Service Chiefs may exclude certain physicians from this training based upon lack of clinical

contact or medical reasons. Required BLS training for psychologists, pathologists, optometrists, and podiatrists is determined by the respective Service Chief: Medical Center Memorandum, CARDIOPULMONARY RESUSCITATION AND LIFE SUPPORT TRAINING FOR STAFF.

13. DISCLOSURE POLICY

MHVAHCS and respective Practitioners have an obligation to disclose adverse events to patients who have been harmed in the course of their care, including cases where the harm may not be obvious or severe, or where the harm may only be evident in the future. The patient is free to involve family members in the disclosure process. NOTE: If the patient is deceased, incapacitated, or otherwise unable to take part in a process of adverse event disclosure, the process needs to involve the patient's representative and anyone who is designated by the representative; Medical Center Memorandum, DISCLOSURE OF ADVERSE EVENTS TO PATIENTS.

14. QUALITY MANAGEMENT

MHVAHCS strives to ensure the scope of the Quality Management System (QMS) is Facility-wide and includes VA Staffed and Contracted Outpatient Clinics. It is organized, systematic, and requires the continuous effort by all services and all employees to achieve excellence in delivery of health care services and a safe environment. This is accomplished by identifying deficiencies, evaluating and maintaining internal controls, implementing improvements, measuring outcomes, and analyzing trends. The QMS emphasizes accountability of all Facility personnel for appropriateness of patient care, treatment and services provided, effective utilization of resources, patient, employee and visitor safety; Medical Center Memorandum, QUALITY MANAGEMENT PLAN.

15. REQUIREMENT FOR TIME AND ATTENDANCE

It is the policy of the MHVAHCS, in regards to Part-time Physician services to procure said services through the employment or contracting authority that best suits their anticipated utilization; Medical Center Memorandum, TIME AND ATTENDANCE FOR PART-TIME CLINICIANS.

16. PATIENT SAFETY INITIATIVES

It is the policy of the MHVAHCS to ensure that quality patient care and services will be provided in an environment that is structured to identify, investigate and minimize risk to patients, visitors and staff. The goal of this program is to minimize the chance of untoward outcomes related to medical care; Medical Center Memorandum, PATIENT SAFETY IMPROVEMENT PROGRAM.

17. CONFLICT OF INTEREST

Business activities and health information practices will be conducted in accordance with all laws, regulations, and industry standards which apply in order to maintain the highest level of professional and ethical standards in the conduct of clinical and administrative operations; Medical Center Memorandum, COMPLIANCE AND BUSINESS INTEGRITY (CBI) PROGRAM.

18. RESTRAINT AND SECLUSION

MHVAHCS will strive to become as restraint free as possible. The commitment is to protect every patient's health and safety and to preserve their dignity, rights, and well-being. The training and competency of direct care staff, as well as any other staff involved in the use of restraints and seclusion, includes information regarding potential consequences of restraint use and is validated initially and annually. The use of restraint will be limited to occurrences in which there is an imminent risk of a patient harming himself/herself or others, including staff. Restraints will be used only when non-physical interventions are ineffective or not viable. Restraint and/or seclusion shall never be used on an as needed basis, as coercion, discipline, punishment, or retaliation by staff or for the convenience of staff. The type of physical intervention selected will take into consideration information learned from the patient's initial assessment. Alternative/least restrictive measures will be utilized in all cases. Employing the least restrictive method will provide safe and effective care to patients; Clinical Memorandum, RESTRAINT AND SECLUSION.

19. SUICIDE ASSESSMENT

All Practitioners are responsible for assuring that all patients presenting with behavioral health issues are assessed for suicide risk as established in this policy. All non-Mental Health Practitioners are responsible for consulting Mental Health in the management of all patients at risk for suicide. Emergency Department Practitioners must involve Mental Health staff present in the Emergency Department or on-call for the Emergency Department in the assessment of all patients with behavioral health issues. Mental Health Practitioners in the Emergency Department will complete a risk assessment and safety plan on all referred mental health patients that check into the Emergency Department. The safety plan will be reviewed with the patient, significant other or family member(s) and a copy will be provided to the patient; Clinical Memorandum, SUICIDAL PRECAUTIONS FOR PATIENTS IN THE MEDICAL CENTER.

20. REQUEST FOR A 30 DAY NOTICE

In order to assist in ensuring consistent patient care and maintaining clinical access for our Veterans, core principles to which all Practitioners are dedicated, it is requested that Title 38 and Hybrid Title 38 providers furnish at least 30 days advance notice, whenever feasible, of separation from VA service. This includes resignation, retirement, or transfer to another VA Facility. The notice should be

in writing, include the projected date of separation or transfer, and su◆mitted to the Practitioner's first line supervisor.

Adopted by the Medical Staff Mountain Home VA Healthcare System, Mountain Home, Tennessee, this 30th Day of September 2015.

RECOMMENDED:

David S. Hecht, MD, MBA Chief of Staff

APPROVED:

Charlene S. Ehret, FACHE Director

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Date

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Date

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MEDICAL STAFF BYLAWS OF THE

VA TENNESSEE VALLEY HEALTHCARE SYSTEM DEPARTMENT OF

VETERANS AFFAIRS

March 27, 2015

Reviewed Date: April 20, 2015

Revised Date: March 27, 2015

TABLE OF CONTENTS

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the Veterans Affairs Tennessee Valley Healthcare System (VATVHS), hereby organize itself for self-governance, and to function with reasonable freedom and confidence in conformity with the laws, regulations and policies governing the Veterans Health Administration (VHA) and the bylaws and rules hereinafter stated. These Bylaws are consistent with all laws and regulations governing Department of Veterans Affairs (VA), and they do not create rights or liabilities not otherwise provided for in laws or VHA regulations. Medical Staff Bylaws shall be consistent with VA policy. Policies created within VA TVHS shall not conflict with the Medical Staff Bylaws and Medical Staff Rules and Regulations, nor shall policies conflict with each other.

VATVHS is a tertiary integrated healthcare system comprised of two hospitals, the Alvin C. York Campus in Murfreesboro, TN, and the Nashville Campus in Nashville, TN, and community based outpatient clinics located in Tennessee and Kentucky.

Portions of these Bylaws are required by the VA, VHA, or The Joint Commission (TJC). These sections should be maintained in accordance with all current regulations, standards or other applicable requirements. Prior versions of Bylaws must be maintained in accordance with Sarbanes-Oxley Act which states that Bylaws are permanent records and should never be destroyed. They must be maintained in accordance with Record Control System (RCS) 10- 1,10Q.

The VATVHS is committed to improving the health of veterans through a comprehensive and high quality healthcare system that focuses on each veteran's special needs. The integrated system provides an environment that fosters healthcare, research and encourages learning. Our vision is to become the healthcare system of choice for veterans. The values of this medical center are the core of all endeavors in fulfilling our mission and provide a focus for the services we provide. Five core values serve as the cornerstone of our commitment to the veterans we serve: Trust, Respect, Commitment, Compassion, and Excellence.

The medical staff complies with the medical staff bylaws, rules and regulations and policies.
The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances, and taking action in others. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

DEFINITIONS (in alphabetical order)

Veterans Affairs Tennessee Valley Healthcare System is abbreviated and identified as VATVHS.

Academic Partnership Council: The APC is established by formal memoranda of affiliation between VATVHS and medical and dental schools and approved by the Under Secretary for Health. They are composed of Deans and senior faculty members of the affiliated medical and dental schools and other academic institutions as appropriate and representative(s) of the medical/dental staffs of VATVHS. They provide academic oversight and review professional appointments.

Annex: A community based clinic within 5 miles of either of the main campuses at Murfreesboro or Nashville.

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.

Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when service in the capacity of Acting Facility Director.

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. The 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.

Automatic Suspension of Privileges: Automatic suspensions are enacted whenever the defined indication occurs. They do not require discussion, investigation or reporting if less than 30 days. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Medical Executive Board.

Chief of Staff: The Chief of Staff is the individual appointed by the Governing Body whose responsibilities are both administrative and clinical in nature. Clinical responsibilities are

defined as those involving professional capability as a practitioner such as to require the exercise of clinical judgment with respect to patient care. The Chief of Staff is President of the Medical Staff and Chairperson of the Medical Executive Board. He/she collaborates with the Chief Operating Officers at the Nashville and Murfreesboro Campuses, and the Associate Director for Nursing in the formation and supervision of the administrative activities inherent in assigned services. He acts as a full assistant to the Director in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioner, Mid-level Practitioners and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of medical staff.

Chief Operating Officers: The Chief Operating Officers fulfill the responsibilities of the Director as defined in these Bylaws when serving in the capacity of Acting Health System Director.

Community Based Outpatient Clinic (CBOC): A CBOC is a health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients. A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures.

Credentialing: Credentialing is the systematic process of screening and evaluating qualifications and other credentials of applicants to assure that they possess the required education, training, license, registration, certification, experience, and skill to fulfill the requirements of appointment.

Director: The Director (Chief Executive Officer) is appointed by the Under Secretary for Health and the Secretary of the Department of Veterans Affairs to act on their behalf in the overall management of the VATVHS. The Director reports directly to the Network Director and is assisted by the Chief of Staff (COS), the Medical Executive Board (MEB), the Chief Operating Officers (COO), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS) and the Associate Director for Nursing. The Director is chairperson of the Governing Council. The Director is responsible for ensuring local facility policy, including Medical Staff Bylaws and Medical Staff Rules and Regulations are consistent with the VHA Handbook 1100.19.

Functional Statement: An official statement of the major duties and responsibilities assigned by management to a position. It must contain all pertinent information related to the position to ensure accurate job-related documentation. The following positions are included but not limited to: audiologist, biomedical engineer, dental assistant, dental hygienist, dietician, diagnostic radiologic technologist, kinesiotherapist, licensed practical nurse, medical instrument technician,

medical record administrator, medical record technician, medical technologist, nuclear medicine technologist, clinical nurse specialist, occupational therapist, occupational therapy assistant, orthotist-prosthetist, pharmacist, pharmacy technician, physical therapist, physical therapy assistant, prosthetic representative, registered nurse, registered and certified respiratory therapist, social worker, speech pathologist, and therapeutic radiologist technologist.

Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the Facility Director. The Director is responsible for the oversight and delivery of health care by all employees and specifically including the medical staff credentialed and privileged by the relevant administrative offices and facility approved processes.

Impaired Practitioner: An individual who is credentialed and privileged to provide direct patient care or does so under a scope of practice or functional statement but is unable to provide such care because of physical illness, mental illness or substance abuse.

Just Cause: Just cause is a burden of proof or standard that an employer must meet to justify discipline or discharge. Also known as Bare sagen, it is a common standard in labor arbitration that is used in labor union contracts in the United States as a form of job security. Typically, an employer must prove just cause before an arbitrator to sustain an employee's termination, suspension or other discipline. Usually, the employer has the burden of proof in discharge cases or if the employee is in the wrong.

Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the VATVHS to provide care and service 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 and psychologists. It may also include individuals who can practice independently, who meet this criterion for independent practice.

Licensure: Licensure refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license or registration.

Medical Executive Board: Executive committee of the medical staff is chaired by the Chief of Staff and empowered to act on behalf of the medical staff. It carries out its work within the medical staff functions of governance, leadership, and performance improvement activities.

Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the medical staff process who are subject to the medical staff Bylaws. This

body may include others, such as retired Practitioners who no longer practice in the organization but wish to continue their membership in the body. The medical staff includes both members of the organized medical staff and non-members of the organized medical staff who provide health care services.

Mentoring: Mentoring is a process for the informal transmission of knowledge, social capital, and the psychosocial support perceived by the recipient as relevant to work, career, or professional development. Mentoring entails informal communication, usually face-to-face and during a sustained period of time, between a person who is perceived to have greater relevant knowledge, wisdom, or experience (the mentor) and a person who is perceived to have less (the protégé).

Mid-Level Practitioner: Mid-Level Practitioners are those health care professionals who are not physicians and dentists and who, most often, function within a Scope of Practice but may practice independently on defined clinical privileges as defined in these Bylaws. Mid-Level Practitioners include: physician assistants (PA), Clinical Pharmacists (PharmDs), and advanced practice nurses (ARNP, CRNA, and CRNP). Mid-Level Practitioners 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 Practitioner when required. Mid-Level Practitioners do not have admitting privileges. Mid-Level Practitioners may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations. Advanced Registered Nurse Practitioners and other health care professionals may be granted defined clinical privileges when allowed by law and the facility.

Nurse Executive (Associate Director for Nursing): The Nurse Executive is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he is the Chairperson of the Nursing PSB and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant mid-level and certain associated health staff and in ensuring the ongoing education of the nursing staff.

On Site: On site refers to the main campuses at Murfreesboro and Nashville, and all CBOCs, including contract CBOCs and Annexes.

One Standard of Care**:** In the context of credentialing and privileging the requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same.

Organized Medical Staff: The body of Licensed Independent Practitioners who are collectively responsible for adopting and amending medical staff Bylaws (i.e., those with voting privileges) and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges.

Outpatient Clinic: An outpatient clinic is a healthcare site whose location is independent of medical facility, however; oversight is assigned to a medical facility.

Patient Safety**:** Patient Safety is ensuring freedom from accidental or inadvertent injury during health care processes. The goal is to prevent harm and injury to patients, visitors and personnel, and improve in the credentialing process.

Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner- specific data collected from various sources for the purpose of evaluating current competence.

Performance Improvement: The term refers to the system-wide effort established by the healthcare system to ensure the highest quality of patient care delivery by assessing patient care and other support processes in a systematic, ongoing manner to identify improvement opportunities and address them in a timely manner.

Primary Source Verification: Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be documented in the form of a letter, telephone contact, secure electronic communication with the original source, or when required by VA policy, it may be a transcript received directly from the issuing institution.

Privileging: The process by which a licensed independent practitioner (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.) is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training and licensure. Privileges must be facility-specific and provider-specific.

Proactive Disclosure Service (PDS): Continuous monitoring service through the National Practitioner Data Bank (NPDB) that notifies subscribing entities when new or updated NPDB and/or Healthcare Integrity and Protection Data Bank (HIPDB) reports are received. PDS notifies subscribers of a report on their enrolled practitioners within 24 hours of receipt by the Data Bank.

Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.

Professional Standards Board (PSB): The Professional Standards Board acts as a Credentials Committee on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matters to the Medical Executive Board as defined in these Bylaws. The PSB also may act on matters involving Associated Health and Mid-Level Practitioners such as granting prescriptive authority, scope of practice, and appointment. Some professional standards boards (e.g. Nursing, Psychology, Pharmacy, etc) are responsible for advancement and other issues related to their respective professions. The Chief of Staff is Chairman of the PSB.

Rules: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the Bylaws. They can be reviewed and revised by the Medical Executive Board and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.

Scope of Practice**:** Scope of practice is a term used by state licensing boards for various professions that define the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency.

Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider.

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.

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).

VetPro**:** VetPro is an Internet enabled data bank for the credentialing of VHA health care providers that facilitates completion of uniform, accurate and complete credentials file.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs Tennessee Valley Healthcare System (VATVHS).

ARTICLE II. PURPOSE

The purpose of the Medical Staff shall be to:

1. Assure that all patients treated at the VATVHS, receive safe, efficient, timely and appropriate care within the resources of the healthcare system, in accordance with the community standards of care, and subject to continuous quality improvement practices.

2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.

3. Establish and assure adherence to ethical standards of professional practice and conduct.

4. Develop and adhere to system specific standards and mechanisms for appointment to the Medical Staff and delineation of clinical privileges.

5. Provide and prioritize system-sponsored educational activities that relate to type and nature of care, treatment and services provided, findings of quality of care review activities, findings of performance improvement and expressed needs of caregivers and recipients of care

6. Ensure a high level of professional performance of practitioners authorized to practice in the facility, through the appropriate delineation of clinical privileges, the ongoing review and evaluation of each practitioner's performance, and continuous quality improvement practices.

7. Assist the Medical Executive Board and the Governing Council in developing and maintaining rules for Medical Staff governance and oversight and provide a means whereby problems of a medical-administrative nature may be discussed by the Medical Staff and the Governing Body.

8. Provide clinical leadership in the management of deliberations of the VATVHS Director and Governing Body that impact patient care, policy, procedure, continuous performance improvement, organizational management and strategic planning.

9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.

10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.

11. Ensure licensed independent practitioners (LIPs) authorized to practice in the facility do so within their delineated clinical privileges.

12. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.

13. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.

14. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational publications.

15. Coordinate and supervise the scope of practice of all Mid-Level and appropriate Associated Health Practitioner staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each Mid-Level and appropriate Associated Health Practitioner should have a scope of practice statement or privileges as well as the means employed to coordinate and supervise their function with the medical staff.

16. Ensure associated health professionals practice within their authorized functional statement.

17. Provide medical backup to the Department of Defense in times of emergency.

18. Initiate and pursue corrective action with respect to members where warranted.

19. Establish and amend, as needed the Medical Staff Bylaws, Rules and Regulations, and policies for the effective performance of Medical Staff responsibilities.

20. Enforce and comply with Medical Staff Bylaws.

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 professionally competent, licensed physicians, dentists, optometrists, podiatrists, and clinical psychologists, who continually meet the qualifications, standard and requirements of VHA, VATVHS, and these Bylaws. The Director, based on recommendations from the Medical Executive Board, may consider membership for other licensed independent practitioners who are permitted by law to provide patient care service independently and who meet the qualifications, standards and requirements of VHA, VATVHS, and these Bylaws, Rules and Regulations.

2. **Categories of the Medical Staff**:

a. Active Medical Staff consists of full-time and part-time physicians, dentists, optometrists, podiatrists and clinical psychologists who are professionally responsible for specific patient care and/or education and/or research activities at VATVHS and who assume all the functions and responsibilities of membership on the active staff. They may hold faculty appointments in the school of their discipline. They will actively participate in quality improvement activities required of the staff. Members of the active medical staff are appointed to a specific, professional medical staff service and are eligible to serve and vote on medical staff committees. A member will satisfy the requirements for attendance at meetings of the Medical Staff, the service, and committees they are assigned.

b. Associate Medical Staff shall consist of intermittent, consultants, telemedicine consultants, contract, fee basis, and without compensation (WOC) staff who complement the members of the active Medical Staff in their roles in patient care, education and research. Members of the associate Medical Staff are appointed to specific professional medical staff services. The associate staff members are not required but are eligible to serve and vote on Medical Staff committees. They may attend the meetings of the Medical Staff but cannot vote.

3. Decisions regarding Medical Staff membership are made without discrimination for reasons such as race, color, religion, national origin, gender, sexual orientation, lawful partisan political affiliation, marital status, physical or mental handicap when the individual is qualified to do the work, age, membership or non-membership in a labor organization, or on the basis of any other criteria unrelated to professional qualifications.

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

1. **Criteria for Clinical Privileges**: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial.

a. Active, current, full and unrestricted license to independently practice the individual's profession in a State, Territory or Commonwealth of the U.S. or the District of Columbia as required by VA employment policies and procedures, or limited, institutional state license expressly stating that the individual may practice at this healthcare system as per the exceptions listed for the full and unrestricted license requirements listed in VA Handbook 5005, Part II, Chapter 3, paragraph 4b. Failure to maintain at least one unrestricted license and/or involuntary termination of any license will result in automatic termination of the practitioner's clinical privileges and appointment to TVHS.

b. Education applicable to individual medical staff members as defined, e.g., hold a degree of Doctor of Medicine or equivalent (MBBS), Osteopathy, Dentistry, Optometry, Podiatry or a doctoral degree in Psychology from an approved college or university.

c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training (see policy on "Basic Life Support and Advanced Cardiac Life Support Training").

d. Current competence consistent with the individual's assignment and the privileges for which applying, including recent privileges held. For new appointments to the medical staff, current competence is documented by recommendations from peers and supervisors, attesting to the applicant's ability to perform satisfactorily the privileges requested.

e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.

f. Complete information consistent with the requirements for application and clinical privileges as defined in Articles VI and VII of these Bylaws and the healthcare system policy on Credentialing and Privileging for a position for which VATVHS has the patient care need, adequate facilities, support services and staff.

g. Satisfactory findings relative to previous professional competence and professional conduct and ethical standards.

h. Proficiency in the English language must be demonstrated.

i. Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.

j. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver's license or passport.

k. Ability to meet response time criteria established for the service as applicable.

2. **Clinical Privileges and Scope of Practice**: While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent Practitioners are permitted by this Facility and these Bylaws to practice independently. All Practitioners listed below are subject to the Bylaws whether they are granted defined clinical privileges or not.

a. The following Practitioners will be credentialed and privileged to practice independently:

(1) Physicians

(2) Dentists

(3) Psychologists

(4) Optometrists

(5) Podiatrists

b. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:

(1) Doctors of Pharmacy

(2) Clinical Pharmacists

c. The following Practitioner will be credentialed and will practice under a Scope of Practice with appropriate supervision:

Physician Assistants.

d. The following Practitioners 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

(2) Clinical Social Workers

(3) Audiologists

(4) Speech Pathologists

(5) Advanced Practice Nurses

(6) Clinical Social Workers

(7) Audiologists

(8) Speech Pathologists

3. **Change in Status:** Members of the Medical Staff as well as all Practitioners practicing through privileges or a scope of practice must agree to provide care to patients within the scope of their Delineated Clinical Privileges or Scope of Practice and advise the Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges which are held, and any changes in the status of professional credentials, such as, but not limited to, loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society as soon as able, but no longer than 15 days after notification of the practitioner.

Section 3.03 Code of Conduct

1. **Acceptable Behavior**: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being on duty as scheduled. (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

2. **Behavior or Behaviors That Undermine a Culture of Safety (BUCS)**: VA recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. VA strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact.

BUCS 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 BUCS 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, BUCS may reach a threshold such that it constitutes grounds for further inquiry by the Medical Executive Committee into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action.

VA distinguishes BUCS from constructive criticism that is offered in a professional manner with the aim of improving patient care. VA also reminds its providers of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a provider's health and performance. Providers suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing BUCS 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 BUCS by taking a role in this process when appropriate.

3. **Professional Misconduct:** Behavior by a professional that creates the appearance of a violation of ethical standards or has compromised ethical standards will not be tolerated.

Section 3.04 Basic Responsibilities of Medical Staff Membership

1. Licensed independent practitioners, both members and non-members of the Medical Staff, are accountable for and have responsibility for:

a. Providing for continuous care of patients assigned to their care and to arrange for transfer of care when appropriate. The care should be of the quality and efficiency generally recognized as standard within his/her profession and area of expertise.

b. Observing patient's rights in all patient care activities.

c. Participating in the improvement in organizational performance and patient safety through active participation in continuing education, peer review, patient incident reporting, Medical Staff monitoring and evaluation and the organization wide Systems Redesign Program. Members of the Medical Staff have a responsibility to contribute to, actively participate in, and, where appropriate, lead process improvement activities.

d. Maintaining standards of ethics and ethical relationships including a commitment to:

(1) Abide by Federal law and VA rules and regulations regarding financial conflict of interest and outside professional activities for remuneration.

(2) Provide care to patients within the scope of privileges or scope of practice and advise the Director through the Chief of Staff of any changes in ability to fully meet the criteria for Medical Staff membership or to carry out clinical privileges held or functions delineated in a scope of practice. When a clinical issue or problem is outside the practitioner's clinical privileges or scope of practice, he/she must seek consultation from a practitioner with the appropriate privileges or from his/her supervisor.

(3) Advise the VATVHS Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of notification of such occurrences and their outcome consistent with requirements under Article IV of these Bylaws.

(4) Contribute to, and abide by, high standards of ethics in professional practice and conduct applicable to the individual's discipline of training, e.g., AMA, ADA.

(5) Abide by the established guidelines for supervision of participants in the professional graduate education programs. (Refer to policy on graduate medical education, associated health professionals)

e. Prepare and complete, in a timely manner, the required clinical records of all patients for whom he/she provides care at this medical center.

f. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the VATVHS and VHA.

g. Apply for renewal of clinical privileges within the time frame allowed (preferably at least three (3) months in advance) to ensure that current privileges do not lapse.

Section 3.05: Conflict Resolution and Management

For the VA to be effective and efficient in achieving its goals the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict Management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program*, addresses the conflict resolution and management process available in the 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 the 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: Memorandum on Alternative Dispute Resolution for Workplace Disputes (February 8, 2007), VA Directive 5978 and VA Handbook 5978.1.

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. The only officer of the Medical Staff is the Chief of Staff, who functions as the President and chairs the Medical Executive Board. He/she is a member of the Academic Partnership Council. The Chief of Staff is a member of the Medical Staff, appointed by the Governing Body whose responsibilities are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner such as to require the exercise of clinical judgment with respect to patient care. The Chief of Staff is President of the Medical Staff. He/she collaborates with the Chief Operating Officers at the Nashville and Murfreesboro Campuses, and the Associate Director for Nursing in the formation and supervision of the administrative activities inherent in assigned services. The method of selection, qualifications, and responsibilities, tenure in office, and conditions and mechanisms for removing from office will be in accordance with applicable VHA Handbook 5005; and VHA M-2, Part 1, Chapter, "Chief of Staff Responsibilities."

2. The Deputy Chief of Staff is fully responsible to the VATVHS Chief of Staff to provide oversight and leadership for the clinical, teaching and research functions at TVHS. The Deputy Chief of Staff's responsibilities include coordinating programs with the Vanderbilt Medical School, Meharry Medical School and enhancing clinical and research programs in the TVHS. Specific assignments will reflect workforce development and succession precepts for potential future advancement.

3. Medical Staff Leadership, Chairs of Medical Staff Committees, and all service-level staff with responsibility for the credentialing and privileging process complete the one time training determined by the Office of Quality and Performance (OQP) within 3 months of assuming their position. This training is accessed through the VA Learning Management System. It also includes the Chief of Staff, System Director, Credentialing staff, and Quality Management professionals (specialists and Chief, QMS), including the Risk Manager.

Section 4.02 Leadership

1. The Chief of Staff is fully responsible to the VATVHS Director for programs of patient care and for the educational and research activities of the clinical services. To carry out these responsibilities, the Chief of Staff:

a. Formulates and recommends plans for a comprehensive program of medical care.

b. Develops the requirements of staff, facilities, equipment and supplies needed to carry forward such an integrated program, utilizing necessary reviews and controls.

c. Appraises the effectiveness of the various medical programs in meeting the needs of patient care.

2. The Deputy Chief of Staff is fully responsible to the VATVHS Chief of Staff to provide oversight and leadership for the clinical, teaching and research functions at TVHS. The Deputy Chief of Staff's responsibilities include coordinating programs with the Vanderbilt Medical School, Meharry Medical School and enhancing clinical and research programs in the TVHS. Specific assignments will reflect workforce development and succession precepts for potential future advancement.

3. The Organized Medical Staff, through its committees and Service Chiefs, provides counsel and assistance to the Chief of Staff and Director regarding all facets of patient care, treatment, and services including evaluating and improving the quality and safety of patient care services.

Section 4.03 Clinical Services

1. Characteristics:

a. Clinical Services are organized to provide clinical care and treatment under leadership of a Service Chief.

b. Clinical Services hold service-level meetings at least monthly with a minimum of 10 per year.

c. The Medical Staff shall be organized into services or care lines. Each medical staff service shall function under the leadership of the Service Chief. A service may be further divided, as appropriate, into sections which shall be directly responsible to the service chief within the service in which it functions. When appropriate, the Chief of Staff may recommend to the VATVHS Director for his/her approval the creation, modification, elimination, or combination of services or sections.

d. Medical Staff Services/Care Lines include:

(1) Anesthesiology

(2) Dental

(3) Geriatrics and Extended Care Line

(4) Medical Imaging Service

(5) Medicine

(6) Mental Health Care Line

(7) Neurology

(8) Pathology and Laboratory Medicine

(9) Physical Medicine and Rehabilitation

(10) Primary Care

(11) Surgery

(12) Transplant

e. Each Medical Staff Service/Care Line provides patient care according to its written goals and Scope of Services as approved by the Medical Executive Board and VATVHS Director.

2. Functions:

a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety, (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; patient safety and risk management activities; and utilization management.

b. Assist in identification of important aspects of care for the Service, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities.

c. Maintain records of meetings that include reports of conclusions, data, recommendations, responsible person, actions taken, and an evaluation of effectiveness of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum of nine per year.

d. Develop criteria for recommending clinical privileges for members of the Service and ensure that ongoing professional practice evaluation is continuously performed and results are utilized at the time of re-privileging.

e. Define and/or develop clinical privilege statements including levels (or categories) of care that include all requirements of VHA Handbook 1100.19.

f. Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within the Service.

g. Annually review privilege templates for each Service and make recommendations to MEB.

3. Selection and Appointment of Service Chiefs: Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff.

a. Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff. Service Chiefs shall be board certified by the appropriate specialty board or possess comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. They are appointed by the VATVHS Director, based upon the recommendation of the Chief of Staff, and approved by the VISN 9 Executive Resource Board, and, if appropriate, the VHA Headquarters Program Director.

b. Service Chiefs who are not a physician or dentist will be assisted by a Senior Physician or Dentist who must meet qualifications established by the Professional Standards Board.

c. Board certified if applicable in the clinical specialty area in which they will practice is preferred as an objective indication of clinical skill and a measure of quality in the delivery of

patient care. Physicians who are not board certified or eligible for board certification may be appointed as outlined in VHA Handbook 1100-19, Credentialing and Privileging. Clinical Service Chiefs must be board certified, if applicable, by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty not appropriate for the assignment, the PSB affirmatively establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. Appointment of service chiefs without board certification will comply with the VHA policy for these appointments as appropriate (Element 36 – Qualifications).

4. Duties and Responsibilities of Service Chiefs: The Service Chief is administratively responsible for the operation of the Service and its clinical and research efforts, as appropriate. In addition to duties listed below, the Service Chief is responsible for assuring the Service performs according to applicable VHA performance standards. These are the performance requirements applicable to the Service from the national performance contract, and cascade from the overarching requirements delegated to the Chief of the Medical Staff. These requirements are described in individual Performance Plans for each Service Chief. Service Chiefs are responsible and accountable for:

a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as Service Chief.

b. Clinically related activities of the Service.

c. Administratively related activities of the department, unless otherwise provided by the organization.

d. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges through FPPE/OPPE.

e. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service.

f. Recommending clinical privileges for each member of the Service.

g. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the Service and communicating the recommendations to the relevant organizational authority.

h. The integration of the Service into the primary functions of the organization.

i. The coordination and integration of interdepartmental and intradepartmental services.

j. The development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.

k. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.

l. The determination of the qualifications and competence of service personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services.

m. The continuous assessment and improvement of the quality of care, treatment, and services.

n. The maintenance of and contribution to quality control programs, as appropriate.

o. The orientation and continuing education of all persons in the service.

p. The assurance of space and other resources necessary for the service defined to be provided for the patients served.

q. Annual review of all clinical privilege forms to ensure that they correctly and adequately reflect the services being provided at the facility. This review is noted by date of review being included on each privilege delineation form.

r. Assuring appropriate supervision of House Staff assigned to the Service consistent with rules, regulations and policies.

s. Participation as a member of the Medical Executive Board.

t. Supervision and identification of medical staff that have been granted disaster privileges when the VATVHS Director has activated the Emergency Management Plan.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.

2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.

3. The presence of 50% of a committee's members will constitute a quorum.

4. The members of all standing committees, other than the MEB, are appointed by the Chief of Staff subject to approval by the MEB, unless otherwise stated in these Bylaws.

5. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff.

6. Robert's Rules of Order Newly Revised will govern all committee meetings.

Section 5.02 Medical Executive Board

1. **Characteristics**: The Medical Executive Board (MEB) serves as the Executive Committee of the Medical Staff. The members of the MEB are:

a. Chief of Staff, Chairperson, voting

b. Clinical Service Chiefs, voting

(1) ACOS, Ambulatory Care

(2) ACOS, Education

(3) ACOS, Geriatrics and Extended Care

(4) ACOS, Research and Development

(5) Chief, Anesthesiology Service

(6) Chief, Dental Service

(7) Director, GRECC

(8) Chief, Medical Imaging Service

(9) Chief, Medicine Service

(10) Chief, Mental Health Care Line

(11) Chief, Neurology Service

(12) Chief, Pathology and Laboratory Medicine Service

(13) Chief, Physical Medicine and Rehabilitation

(14) Chief, Primary Care

(15) Chief, Surgery Service

(16) Practitioners appointed through the medical staff process

(17) Director, or designee, ex-officio, non-voting

(18) Nurse Executive, ex-officio, non-voting

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. The non-voting members include:

(1) Chief, Audiology and Speech Pathology Service

(2) Chief, Chaplain Service

(3) Chief, Clinical Informatics Officer

(4) Chief, Education Service (DLO)

(5) Chief, Nutrition and Food Service

(6) Chief, Pharmacy Service

(7) Chief, Quality Management Service

(8) Chief, Social Work Service

(9) Compliance Officer

(10) Administrative Assistant to the Chief of Staff

(11) Representative, AFGE 1844

(12) Representative, AFGE 2400

d. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

2. **Functions of the MEB:** The MEB:

a. Acts on behalf of the Medical Staff between Medical Staff meetings within the scope of its responsibilities as defined by the Organized Medical Staff.

b. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process in support of clinical privileges and/or scope of practice requested; to address the scope and quality of services provided within the facility.

c. Acts to ensure effective communications between the Medical Staff and the Director.

d. Makes recommendations directly to the 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 Practitioner credentialed.

e. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.

f. Oversees process in place for instances of "for-cause" concerning a medical staff member's competency to perform requested privileges.

g. Oversees process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.

h. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.

i. Monitors medical staff ethics and self-governance actions.

j. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.

k. Receives and acts on reports and recommendations from medical staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body.

l. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.

m. Acts upon recommendations from the PSB.

n. Acts as and carries out the function of the Physical Standards Board, which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician. The Physical Standards Board may have the same membership as the local physician Professional Standards Board or members may be designated for this purpose by the Health System Director. Boards may be conducted at other VA healthcare facilities.

o. Provides oversight and guidance for fee basis/contractual services.

p. Annually reviews and makes recommendations for approval of the Service-specific privilege lists.

3. **Meetings**:

a. **Regular Meetings**: Regular meetings of the MEB shall be held at least nine times per year with meetings following every scheduled PSB meeting. 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 MEB when necessary to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the MEB.

b. **Emergency Meetings**: Emergency meetings of the MEB may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the MEB, the Director as the Governing Body or Acting Chief of Staff may call an emergency meeting of the Committee.

c. **Meeting Notice**: All MEB members shall be provided at least 3 days 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 MEB. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.

e. **Quorum**: A quorum for the conduct of business at any regular or emergency meeting of the MEB shall be a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority (50%) vote at any meeting at which a quorum (50%) is present. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

f. **Minutes**: Written minutes shall be made and kept on all meetings of the MEB, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff.

g. **Communication of Action**: The Chair at a meeting of the MEB at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.

4. **Method of Removing Members**: Members of the medical staff can be removed after a two- third's vote at the MEB and will be notified in writing by the Chief of Staff of the removal.

Section 5.03 Committees of the Medical Staff

1. Reporting committees provide a major framework by which the Medical Staff accomplishes performance improvement functions for clinical processes. These committees meet on a frequency as determined by the MEB and medical center policy. Committees prepare and maintain records for discussion, conclusion, recommendations, and action and results of actions taken and are responsible for timely communication of committee activities through channels established by the Medical Staff. Medical Staff, or their designated alternates, are encouraged to attend committee meetings to which they are assigned.

2. Reporting committees are defined in the Medical Executive Board policy. Committee meetings will specify those members in attendance and identify reporting frequency to the MEB.

a. Professional Standards Board of the Medical Staff

(1) Membership. The Professional Standards Board (PSB) is the designated hospital credentialing committee for physicians, dentists, podiatrists, optometrists, clinical psychologists, advanced practice nurses (NPs, CNS, CRNAs), clinical pharmacy specialists, and physician assistants. There are chartered PSBs for various disciplines that report to the Medical Staff PSB. Membership includes the Chief of Staff, Deputy Chief of Staff, designated Clinical Service and

Section Chiefs, a representative from Credentialing and Privileging, a representative from Human Resources Management Service, and the Service or Section Chief representing the specialty of the individual whose credentials are under review. A quorum is 50 percent of voting members and must be present to make recommendations to the VATVHS Director (see policy Professional Standards Board) and must meet at least 12 times per year.

(2) Functions.

(a) The PSB is constituted to examine all documents and pertinent information concerning the appointment, advancement, and probationary review of clinical staff to ensure that the VHA recruits and retains the best-qualified professional personnel. Its functions include, but are not limited to:

(1) Review and recommend action to the Director for acceptance or rejection of each application for appointment and action on each request for initial privileges.

(2) Review and recommendation on proposals for special advancement for performance and/or achievement for members of the Medical Staff.

(3) Review and recommend to the VATVHS Director, in accordance with the Professional Standards Board policy and appropriate VHA Directives and supplements thereto, action on all policies and procedures for appointment, promotion, and advancement of Title 38 associated health professionals.

(b) Composition of the Chartered Boards – Whenever possible, the chartered professional standards boards will be composed of three or five employees from the same occupation as the individual being considered. However, appropriately qualified individuals from other occupations may be appointed, provided the board is composed of a majority of the employees from the occupation involved. When the appropriate minimum number of employees in the occupation is not available or the number of employees is too small to provide for an independent review, an alternate board must be used (VA Handbook 5005/17, Part II, Chapter 3, June 15, 2006).

b. **The Peer Review Committee**

The Peer Review Committee is defined in medical center policy 626-08-00Q-16. The Chief of Staff chairs this committee, oversees the Peer Review Program and is responsible for ensuring the committee functions and meets internal and external reporting requirements in accordance with VA guidelines. The Quality Management Service (QMS) facilitates the peer review process information flow including maintaining documentation and coordinating required reporting. The QMS is responsible for developing and providing quarterly aggregate summary reports of peer

review activity and report quarterly to the MEB in accordance with current VA frequency and format requirements and meets quarterly.

c. **Residency Review Committee:** The Residency Review Committee works with the Vice Chancellor's Committee (Nashville Campus) and the Academic Partnership Council (Alvin C. York Campus), the Associate Chief of Staff for Education, and the clinical services with residents to assure that patients whose care is provided by residents receive the same level of care as that which is provided by medical staff. The Residency Review Committee will assure that residents are given the opportunity to learn in an appropriate setting with appropriate supervision, that their performance meets the expected standards for their level of training, and that the residents observe the same ethical standards as the medical staff. The Committee will report to the PSB but will report at least annually to the MEB.

3. Other committees may be chartered and will need to include charge, composition and meeting frequency.

4. **Information Flow to Medical Executive Board**: All Medical Staff Committees, including but not limited to those listed above, will submit minutes of all meetings to the MEB in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the MEB.

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, at a minimum on a quarterly basis.

2. Each Committee provides appropriate and timely feedback to the Services relating to all information regarding the Service and its providers.

3. Each committee shall review and forward to the MEB, a synopsis of any subcommittee and/or workgroup findings.

Section 5.05 Establishment of Committees

1. The MEB may, by resolution and upon approval of the Director, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions.

2. The MEB may, by resolution and upon approval of the Director, dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

ARTICLE VI. MEDICAL STAFF MEETINGS

1. **Regular Meetings**: Regular meetings of the Medical Staff shall be held at least annually. A record of attendance shall be kept. The Medical Staff must be convened by the Chief of Staff and meets, at a minimum, yearly. Additional meetings may be convened at the call of the Chief of Staff or at the request of the Medical Executive Board. Active Medical Staff members (5/8^{ths} or greater) should attend the annual meeting.

2. **Special Meetings**: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the MEB. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Director in writing and stating the reason(s) for the request.

3. **Quorum**: For purposes of Medical Staff business, 25% of the total membership of the medical staff membership entitled to vote constitutes a quorum. A **quorum** is present when the number of attendees is equal to 51% of all members employed 5/8 FTE or greater.

4. **Meeting Attendance**: Members of the Organized Medical Staff are required to attend 50% of regular Medical Staff meetings and 50% of Service-level meetings.

5. **Medical Staff members** will attend their Service staff meetings and meetings of committees of which they are members unless specifically excused by the Service Chief or Chair, where appropriate, for appropriate reasons, e.g., illness, leave or clinical requirements.

6. **Members of the active Medical Staff** (5/8^{ths} or greater) are voting members. Every member's vote counts equally.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. **Independent Entity**: VA TVHS is an independent entity, granting privileges to the medical staff through the MEB and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Mid-Level Practitioner, and Associated Health Practitioner reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff, Mid-Level, and Associated Health Practitioners must practice under their privileges or scope of practice.

2. **Credentials Review**: All Licensed Independent Practitioners (LIP), Mid-Level and Associated Health Practitioners who will hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. All Mid-Level and Associated Health Practitioners will be subjected to full credentials review at the time of initial appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a maximum period of 2 years minus one day.

3. **Deployment/Activation Status**:

a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be placed in a "Deployment/Activation Status" and the credentialing file will remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of l994 (USERRA), the Practitioner will update the credentialing file to current status.

b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the MEB for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.

c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.

d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief must consider the privileges held

prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care.

4. **Employment or Contract**: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:

a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.

b. Federal law authorizing VA to contract for health care services.

5. **Initial Focused Professional Practice Evaluation:**

a. The initial focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This occurs with a new Practitioner or an existing Practitioner who request a new privilege. The performance monitoring process is defined by each Service and must include:

(1) Criteria for conducting performance monitoring

(2) Method for establishing a monitoring plan specific to the requested privilege

(3) Method for determining the duration of the performance monitoring

(4) Circumstances under which monitoring by an external source is required.

b. An initial Medical Staff Appointment does not equate to HR employment. FPPE does not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below:

(1) Initial and certain another appointments made under 39 U.S.C. 7401(I), 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.

6. **Ongoing Professional Practice Evaluation**:

The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the medical staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for medical staff leadership. Each service chief should consider what hospital, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.

(1) The timeframe for ongoing monitoring is to be defined locally. It is suggested that, at a minimum, service chiefs must be able to demonstrate that relevant practitioner data is reviewed on regular bases (i.e. more than once a year). Consideration may be based on a period of time or a specified number of procedures and may consider high risk or high volume for an adjustment to the frequency.

(2) With very few exceptions, VHA data standing alone is not protected by 38 U.S.C. 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. Data that is not previously identified as protected by 39 U.S.C. 5705 and is collected as provider specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program and compared to predefined facility triggers or de-identified quality management data.

(3) In those instances where a practitioner does not meet established criteria the service chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.

(4) The MEB must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.

(5) The Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

Section 7.02 Application Procedures

1. **Completed Application**: Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines. ***NOTE***: *See VHA 1100.19 for full process*. The applicant is bound to 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 Practitioner says the information provided is factually incorrect.

a. Items specified in Article III, Section 2, Qualifications for Medical Staff Membership, including:

(1) Active, current, full, and unrestricted license. ***Note:*** *In instances where Practitioners have multiple licenses inquiry must be made for all licenses and the process as noted in VHA Handbook 1100.19 must be followed for each license (38USC 7402). Limitations defined by state licensing authorities must also be considered when considering whether licensure requirements are met.*

(2) Education.

(3) Relevant training and/or experience.

(4) Current professional competence and conduct.

(5) Physical and Mental health status.

(6) English language proficiency.

(7) Professional liability insurance (contractors only).

(8) Proof of current BLS certification required for all on site physicians at the time of initial credentialing (excludes off-site teleradiologists and pathologists). See TVHS Memorandum BLS and ACLS Training Requirements for further categories of providers who require current BLS and ACLS training due to assignment to specific functions or areas of the facility.

(9) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and will acknowledge that they have received a copy of "The Sedation and Analgesia by Non-Anesthesia Providers" policy and agree to the guidelines outlined in the policy.

(10) Laser Committee must approve all privileges for laser usage prior to approval of privileges by the PSB.

(11) Geriatrics Board will approve all privileges for providers practicing on the community living center units.

b. **U.S. Citizenship**: Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, Practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment with proof of current visa status and Immigration and Naturalization Service documentation regarding employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.

c. **References:** The names and addresses of a minimum of four individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer or for individuals completing a residency, one reference must come from the residency training program director. The Facility Director may require additional information.

d. **Previous Employment**: A list of all health care institutions or other organizations where the Practitioner is/has been appointed, utilized or employed (held a professional appointment), including:

(1) Name of health care institution or practice.

(2) Term of appointment or employment and reason for departure.

(3) Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary surrender.

e. **DEA/CDS Registration**: A description of:

(1) Status, either current or inactive.

(2) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, the Practitioner's DEA/CDS registration.

f. **Sanctions or Limitations**: Any sanction or penalty by any licensing authority, including current pending challenges, whether a license or registration ever held to practice a health occupation by the Practitioner has been suspended, revoked, voluntarily surrendered, or not renewed.

g. **Liability Claims History**: Status (Open, Pending, Closed, Dismissed, etc.) of any claims made against the Practitioner in the practice of any health occupation including final judgments or settlements, if available.

h. **Loss of Privileges**: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

i. **Release of Information**: Authorization for release of information, including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.

j. **Pending Challenges**: Pending challenges against the Practitioner by any hospital, licensing agency, professional group, or society.

2. **Primary Source Verification**: In accordance with VHA Handbook 1100.19 Credentialing and Privileging and VA Handbook 5005, Part II, Chapter 3 the facility will obtain primary source verification of:

a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article III, Section 2a above.

b. Verification of current or most recent clinical privileges held, if available.

c. Verification of status of all licenses current and previously held by the applicant.

d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.

e. Evidence and verification of board certification or eligibility, if applicable.

f. Verification of education credentials used to qualify for appointment including all postgraduate training.

g. Evidence of registration with the National Practitioner Data Bank (NPDB) Proactive Disclosure Service and the Healthcare Integrity and Protection Data Bank, for all members of the Medical Staff and those Practitioners with clinical privileges.

h. For all physicians screening will be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source

information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner.

i. Confirmation of health status on file as documented by a physician approved by the Organized Medical Staff.

j. Evidence and verification of the status of any alleged or confirmed malpractice. ***NOTE****: It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the Practitioner, requesting all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the Practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint. Questions concerning applicants who may qualify for appointment under the Rehabilitation Act of 1974, need to be referred to Regional Counsel.*

k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made.

3. The applicant's attestation to the accuracy and completeness of the information submitted.

4. **Burden of Proof:** The applicant has the burden of obtaining and producing all needed information for a proper evaluation of the applicant's professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of the request to the applicant may serve as a basis for denial of employment consideration.

5. **VetPro Required**: All healthcare providers must submit credentialing information into VetPro as required by VHA policy.

Section 7.03 Process and Terms of Appointment

1. **Chief of Service Recommendation**: The Chief of the Service or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met.

2. **CMO Review**: In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be submitted to the VISN Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the MEB if the response from the NPDB-HIPDB query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of $550,000 or more, or (c) two medical malpractice payments totaling $1,000,000 or more. The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Chief's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

3. **PSB Recommendation:** The PSB makes recommendations to the VATVHS Director, as delegated by the Medical Executive Board, for Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

4. **MEB Recommendation**: MEB recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

5. **Director Action**: Recommended appointments to the Medical Staff should be acted upon by the Director within 5 work days following approval of the MEB, unless there is a recommendation to not renew or to revoke privileges and 30 days is allotted for the Director's decision.

6. **Applicant Informed of Status:** Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non- appointment, or return of the application because of inadequate information.

a. The applicant will be notified of the Director's decision to not renew or revoke privileges within 10 working days.

b. The applicant may appeal denial of the appointment, in writing to the VATVHS Director within 10 working days of receipt of the Director's decision.

7. When there is an emergent or urgent patient care need as defined in the healthcare system policy on Credentialing and Privileging, temporary VA employment appointment, under the provisions of 38 U.S.C. 7405(a)(1) and VA Handbook 5005, Part II, Chapter 3, paragraph B1f(2), and a temporary Medical Staff appointment may be approved by the VATVHS Director upon recommendation of the Chief of Staff prior to receipt of references or verification of other information and action by the PSB, when applicable. Verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted, initiation of a PDS query and a reference are required prior to making such an appointment.

8. An expedited appointment process may be used in instances where expediting a medical staff appointment is in the best interest of quality patient care. This is a one-time appointment process for initial appointment to the medical staff and may not exceed 60 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 60 calendar days of the expedited appointment or the medical staff appointment is automatically terminated.

a. The expedited appointment credentialing process cannot begin until the LIP completes the credentialing package, including but not limited to:

(1) Complete submittal by the applicant of credentials information into VetPro

(2) Confirmation of the practitioner's education and training

(3) Current license verified by the primary source

(4) Physical and mental health status confirmation

(5) Query of licensure history through the Federation of State Medical Boards Action Data Center

(6) Two peer references

(7) Current comparable privileges held in another institution

(8) Proactive Disclosure Service query

b. The authority to render a recommendation on an expedited appointment for the Director's approval is delegated by the MEB to at least 3 members of the PSB. Two of these members must also be members of the MEB and the third must be the Human Resources Management representative to the PSB.

c. No application will be denied because of race, creed, gender or national origin.

Section 7.04 Credentials Evaluation and Maintenance

1. **Evaluation of Competence**: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff

monitors) that the Practitioner applying for clinical privileges has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.

2. **Good Faith Effort to Verify Credentials**: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The entry will describe the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. It will also indicate when a secondary source, e.g. copy of diploma, confirmation from someone in practice or training at the same time, is being used in lieu of primary-source verification. The applicant should assist in providing required information for this documentation. ***Note:*** *Verification of licensure is excluded from good faith effort in lieu of verification.*

3. **Maintenance of Files:** A complete and current Credentialing and Privileging (C&P) file including the electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C&P file is the responsibility of the Chief of Staff. Any time a file is found to lack required documentation, without an entry as noted above in paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain the documentation.

4. **Focused Professional Practice Evaluation:** A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a "for-cause" event requiring a focused review.

a. An FPPE, implemented at time of initial appointment, will be based on the Practitioner's previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, chart reviews, etc. and should be discussed with the Practitioner by the Service Chief.

b. An FPPE at the time of request for additional privileges will be for a period of time, a number of procedures and/or chart review to be set by the Service Chief.

c. An FPPE initiated by a "for-cause" event will be set by the Service Chief. FPPE for cause, where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges i.e., summary suspension.

d. The FPPE monitoring process will clearly define and include the following:

(1) Criteria for conducting the FPPE.

(2) Method for monitoring for specifics of requested privilege.

(3) Statement of the "triggers" for which a "for-cause" FPPE is required.

(4) Measures necessary to resolve performance issues which will be consistently implemented.

e. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the Service's policies and procedures.

f. If at any time the Service Chief or designee cannot determine the competence of the Practioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:

(1) Extension of FPPE review period

(2) Modification of FPPE criteria

(3) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner)

(4) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported).

Section 7.05 Local/VISN-Level Compensation Panels

Local/VISN-level Compensation Pay Panels recommend the appropriate pay table, tier level and market pay amount for individual medical staff members, as outlined in VA Handbook 5007, Part IX/21. Appointment actions recommended by the Professional Standards Board require a separate review for a pay recommendation by the appropriate Compensation Panel.

Section 7.06 Denial of Medical Staff Appointment

1. The Professional Standards Board, Chief of Staff, or the VATVHS Director may initiate certain corrective actions with regard to Medical Staff members whenever it is deemed in the best interest of patient care and to ensure effective self-governance. These actions may include but are not limited to personnel counseling, mandatory CME additional training or periods of supervision. In addition, service or hospital monitoring information may warrant recommendation for adverse privilege action.

2. The Medical Staff provides for the proctoring or supervision of procedures approved for individuals who have not met minimum service criteria. In accordance with State Licensing Boards and these Bylaws, the Medical Staff will ensure that practitioners meet continuing

education requirements for their specialty. The Medical Staff will also encourage referral of physicians to the Employee Assistance Program when circumstances indicate participation.

ARTICLE VIII. CLINICAL PRIVILEGES

Section 8.01 General Provisions

1. Clinical privileges are granted for a period of no more than 2 years.

2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.

a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.

b. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.

c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the MEB. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7).

3. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Service Chief.

4. Mid-Level Practitioners who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.

5. Requirements and processes for requesting and granting privileges are the same for all Practitioners who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.

6. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all Service Chiefs must recommend the practice.

7. Exercise of clinical privileges within any Service is subject to the rules of that Service and to the authority of that Service Chief.

8. When certain clinical privileges are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.

9. **Telemedicine**: As identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies, telemedicine practitioners, who render care through the use of electronic audio, video or other technologies to provide or support clinical care at distance, are credentialed and privileged through the medical staff mechanisms defined in these Bylaws. The Medical Staff determines which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards. This determination will be made through the Medical Executive Board and documented in the minutes.

10. **Teleconsultation:** All Practitioners providing teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

11. The delineation of clinical privileges must be facility specific, setting specific and provider specific.

12. Each service chief must establish eligibility criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility. The criteria are determined by the service, recommended by the MEB and approved by the facility Director. These criteria for delineation and granting of privileges are reviewed on an annual basis. Privileges are setting specific, within the context of each facility, requiring consideration of each unique setting's characteristics, such as adequate facilities, equipment, and number and type of qualified support staff and resources.

13. Individuals performing procedures outside of the scope of granted privileges may be subject to disciplinary or administrative action. Clinical privileges may be temporarily restricted or suspended when patient safety or other considerations make it necessary and prudent to do so. Service Chiefs may take such action emergently after consultation with the Chief of Staff (see VHA Handbook 1100.19, Credentialing and Privileging).

14. The requesting and granting of clinical privileges for Chiefs of Staff or facility Directors must follow the procedures as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant service chief responsible for the particular specialty area in which they are requesting privileges. When considering clinical privileges for the COS an appropriate practitioner must chair the PSB and the COS must be absent from the deliberations. For a facility Director requesting privileges, the approval authority is delegated to the Associate Director (Chief Operating Officer), who is authorized to act as facility Director for these purposes.

15. Credentialing of Providers Delivering Care Off-Station

a. Fee Program (non-contracted) - The VA refers the veteran to the community and acts as a third party payer. The patient picks the provider and the VA assumes the cost for the care that was authorized. Since the VA is not directing care, the providers do not need to be credentialed and privileged by the VA.

b. Referral to a Specific Provider Group – The VA refers a veteran to a provider group using a contract. As long as the workload is distributed to two or more members of the group and not directed to a single provider in the group, the care is not directed by the VA and the providers are not credentialed and privileged by the VA. The VA is required to monitor the contract to assure that care is distributed among two or more members of the group and not misdirected to a specific provider. If the contract monitoring finds that one person is providing all the service, the person must be credentialed and privileged by the VA.

c. Referral to a Specific Provider – The referral from the VA can be through fee, contract or based on available community services. Because the workload is directed to a single provider, the provider must be credentialed and privileged since the VA is directing the care and chooses to provide the necessary care using this provider.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. **Burden of Proof:** When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper

evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.

2. **Requests in Writing**: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.

3. Credentialing and privileging folder will be established and maintained for each practitioner requesting privileges. These folders will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging not found in VetPro. Any time that a folder is found to lack required documentation for any reason, an effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the folder stating the reason. The entry will also detail the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. Additionally, a Vet Pro account will be maintained for each credentialed provider.

4. **Credentialing Application**: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:

a. Complete appointment information as outlined in Section 2 of Article VI.

b. Application for clinical privileges as outlined in this Article.

c. Evidence of professional training and experience in support of privileges requested.

d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEB.

e. A statement of the current status of all licenses and certifications held.

f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits

or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.

h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

i. Evidence of current successful completion of an approved BLS program meeting the criteria of the American Heart Association is required at the time of initial appointment. Off- station practitioners, such as pathologists and teleradiologists, are exempt from this requirement.

5. **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.

6. **Moderate Sedation and Airway Management**: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that he/she has received a copy of Sedation and Analgesia by Non-Anesthesia Providers policy and agree to the guidelines outlined in the policy.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

1. **Application**: The Practitioner applying for renewal of clinical privileges must submit the following information:

a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.

b. Supporting documentation of professional training and/or experience not previously submitted.

c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEB.

d. Documentation of continuing medical education related to area and scope of clinical privileges, (consistent with minimum state licensure requirements) not previously submitted.

e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.

f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

g. Names and addresses of two peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

h. Names of other hospitals or facility at which privileges are held and requests for copies of current privileges held.

2. **Verification**: Before granting subsequent clinical privileges, the Credentialing and Privileging Office will ensure that the following information is on file and verified with primary sources, as applicable:

a. Current and previously held licenses in all states.

b. Current and previously held DEA/State CDS registration.

c. NPDB-HIPDB PDS Registration.

d. FSMB query

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

g. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and FPPE.

h. Continuous education to meet any local requirements for privileges requested.

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Chief. This request will initiate the recredentialing process as noted in the VHA Handbook 1100.19.

2. Primary source verification is conducted if applicable, e.g. provider attests to additional training.

3. Current NPDB-HIPDB PDS Registration prior to rendering a decision.

4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the MEB followed by the Director's/Governing Body's approval.

Section 8.05 Recommendations and Approval for Initial/Renewal, Modification/Revision of Clinical Privileges

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.

2. The Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.

a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:

(1) Medical/Clinical knowledge (education competency).

(2) Interpersonal and Communication skills (documentation; patient satisfaction).

(3) Professionalism (personal qualities).

(4) Patient Care and Procedural Skills (clinical competency).

(5) Practice-based Learning & Improvement (research and development).

(6) System-based Practice (access to care).

b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE.

3. MEB recommends granting clinical privileges to the Facility Director based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. A subcommittee of MEB can make the initial review and recommendation but this information must be reviewed and approved by the MEB.

4. Clinical privileges are acted upon by the Director within 5 business days of receipt of the MEB recommendation to appoint. The Director's action must be verified with an original signature.

5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A copy of approved privileges is given to the Practitioner and is readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.

6. PSB recommends scope of practice for practitioners with prescribing authority for concurrence to MEB for approval by the Director.

7. Renewal of clinical privileges shall also be based upon:

a. Physical and mental health status as it relates to practitioner's ability to function within privileges requested including such reasonable evidence of health status that may be required by the Professional Standards Board.

b. Supporting documentation of professional training and/or experience not previously submitted.

c. Documentation of a minimum of 40 hours of continuing education every two years related to area and scope of clinical privileges, not previously submitted.

d. Status of all licenses, certifications held.

e. Any sanction(s) by a hospital, state licensing agency or any other professional health care organization; voluntary or involuntary relinquishment of licensure or registration; any malpractice claims, suits, or settlements (including those pending outcomes); reduction or loss of privileges at any other hospital.

f. Compliance to all other provisions of these Bylaws.

8. Verification

a. Initial privilege verification will be accomplished as described in Section 2 of this Article.

b. Reprivileging verification will be accomplished by primary source confirmation of the following as applicable:

(1) All current licensure registrations at the time of appointment and initial granting of clinical privileges, at reappointment, renewal, or revision of clinical privileges, and at the time of expiration.

(2) Current DEA certification.

(3) Proactive Disclosure Service, NPDB-HIPDB, and Federation of State Medical Board queries.

(4) Board Certification obtained within the last 2 years.

9. The renewal of clinical privileges process also includes the updating of information maintained in VetPro.

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 Director or Acting Director on the recommendation of the Chief of Staff. An urgent patient care need includes the following:

a. Temporary privileges are based on verification of the following:

(1) One, active, current, unrestricted license with no previous or pending actions.

(2) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.

(3) Current comparable clinical privileges at another institution.

(4) Response from NPDB-HIPDB PDS 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 calendar days of temporary privileges being granted and credentialing completed.

2. **Emergency Care**: Emergency care may be provided by a member of the Medical Staff 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. Properly supervised house staff may also provide emergency care.

3. **Organ Procurement**: Practitioners designated by the organ procurement organization with which the healthcare system has an authorized memorandum of agreement who are engaged solely at the healthcare system in organ and/or tissue recovery are exempt from requirements to obtain Medical Staff privileges for this purpose. The organ procurement organization is required to certify to the Director or hospital staff involved with the donation that such practitioners are appropriately licensed, insured and authorized to engage in organ and/or tissue recovery.

4. **Disaster Privileges**: As described in the Emergency Management Plan.

a. In the event of the implementation of the organization-wide disaster management plan, Disaster Privileges may be approved by the Director if it is determined that it is not possible to handle the influx of patients with the existing Practitioners. Any of the following will be accepted as credentials verification process for emergency volunteers to provide patient care in the facility:

(1) Evidence of a current license (pocket card sufficient) to practice.

(2) And one of the following:

(a) A current medical facility photo ID card.

(b) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).

(c) Identification that the individual has been granted authority to render patient care in emergency circumstances by a Federal, state, or municipal entity.

(d) Volunteer Licensed Independent Practitioners (LIP) will be given special ID badges stating "Disaster Volunteer" identifying them from other LIPs. The badges will be provided by Police and Security.

(e) The disaster privileges will be terminated immediately upon termination of the declared disaster or at the end of 10 calendar days, whichever is sooner. At the end of this period, the practitioner must be converted to temporary privileges, defined in these Bylaws, or relieved of duty.

(3) Consideration and approval of an initial request for privileges may proceed in conjunction with an expedited appointment as described in the policy on Credentialing and Privileging.

(4) The documentation will serve as credentials verification for a period not to exceed ten (10) calendar days or length of the disaster, whichever is shorter. Primary source verification of licensure will be obtained within seventy-two (72) hours after the disaster is under control, or as soon as possible in extraordinary circumstances.

(5) In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the 10 calendar days or the length of the declared disaster, whichever is shorter, noted in paragraph b above, the Practitioner 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.

(6) An assigned, appropriately credentialed and privileged physician oversees the professional practice of each volunteer, Licensed Independent Practitioner, Mid-Level Practitioner, and Associated Health Practitioner.

(7) The quality of the care and service rendered by each volunteer Practitioner with Disaster Privileges must be evaluated at the end of 72 hours and a determination made as to whether or not the Practitioner will be permitted to continue providing services.

5. **Inactivation of Privileges**: The inactivation of privileges occurs when a Practitioner is not an actively practicing member of the medical staff for an extended period of time such as extended sick leave or sabbatical with or without clinical practice while on sabbatical.

a. When the Practitioner returns to 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 Facility Director ensures that within 7 calendar days of the date of separation, information is received suggesting that Practitioner met generally accepted standard s of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.

6. **Deployment and Activation Privilege Status**: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment. ***NOTE:*** *No step in this process should be a barrier in preventing the Practitioner from returning to the Facility in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994*.

a. Facility staff request that a Practitioner returning from active duty communicate with the Facility staff as soon as possible upon returning to the area.

b. After the electronic credentials file has been reopened for credentialing, the Practitioner must update the licensure information, health status, and professional activities while on active duty.

c. The credentials file must be brought to a verified status. If the Practitioner performed clinical work while on active duty, an attempt is made to confirm the type of duties, the Practitioner's physical and mental ability to perform these duties, and the quality of the work. This information must be documented.

d. The verified credentials, the Practitioner's request for returning the privileges to an Active Status, and the Service Chief's recommendation are presented to the MEB for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the MEB is documented and forwarded to the Director for recommendation and approval of restoring the Practitioner's privileges to Current and Active Status from Deployment and/or Activation Status.

e. In those instances when the Practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.

f. In those instances where the privileges lapsed during the call to active duty, the Practitioner needs to provide additional references for verification and Facility staff need to perform all verifications required for reappointment.

g. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief, must consider whether a request for modification of the privileges held prior to the call to active duty should be initiated on a short- term basis.

h. If the file cannot be brought to a verified status and the Practitioner's privileges restored by the Director, the Practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VetPro:

(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-HIPDB PDS 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.

7. **Residents or fellows** who are appointed outside of their training program to work on a fee basis as Medical or Psychiatric Officer of the Day, perform Compensation and Pension exams, or in the Emergency Department must be licensed, credentialed and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program, and must meet the same requirements of all Medical Staff appointed at the facility.

Section 8.07 Medical Assessment

A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient including any changes in the patient's condition, must be completed and documented by a physician, a maxillofacial surgeon or other qualified licensed individual in accordance with state law, VHA and hospital policy. The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.

ARTICLE IX. INVESTIGATION AND ACTION

1. **Request for Investigation**: Whenever the behaviors, activities and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Behavior or Behaviors That Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Facility Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct, which constitute the grounds for the request. The Chief of Staff promptly notifies the Director in writing of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. ***NOTE***: *If the person under review, is an employee then the processes must also follow VA Directive 5021 - Management of Employees (Appendix A pages 2-9).*

2. **Fact Finding Process**: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article IX, a fact finding process will be implemented. This fact-finding process should be completed within 30 days or there needs to be documentation as to why that was not possible. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities and/or professional conduct the Practitioner are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff or to represent Professional Misconduct, Behavior or Behaviors That Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these

Bylaws, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the Professional Standards Board.

3. **Review by Professional Standards Board**: The Professional Standards Board investigates the charges and makes a report of the investigation to the MEB within 14 calendar days after the PSB has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the PSB to discuss, explain or refute the charges against him/her. 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 PSB 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 MEB.

4. **MEB Action**: Within 14 calendar days after receipt of a report from the PSB, the MEB acts upon the request. If the action being considered by the MEB involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the MEB prior to the committee's action on such request. 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 MEB.

a. The MEB may reject or modify the recommendations; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommend that the Practitioner's staff membership be suspended or revoked.

b. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

c. Reduction of privileges may include, but not be limited to, functioning under supervision[1], restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.

d. Revocation of privileges refers to the permanent loss of clinical privileges.

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[1] See the definition of Proctoring for an explanation of the difference between proctoring and supervision.

5. **Summary Suspension of Privileges**: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, or portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by Facility Director.

a. The Chief of Staff convenes the PSB to investigate the matter, meet with the Practitioner if requested and make a report thereof to the MEB within fourteen (14) days after the effective date of the Summary Suspension.

b. Immediately upon the imposition of a Summary Suspension, the Service Chief or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.

c. Indications for summary suspension of clinical privileges may include, but are not limited to, the following:

(1) Significant deficiencies in clinical practice such as lack of diagnostic or treatment capability; multiple errors in prescribing, administering or documenting medications, inability to perform clinical procedures considered basic to the performance of one's occupation or performing procedures not included in one's clinical privileges in other than emergency situations;

(2) Patient neglect or abandonment;

(3) Mental health impairment sufficient to cause the individual to make judgment errors affecting patient safety, to behave inappropriately in the patient care environment or to provide unsafe patient care;

(4) Physical health impairment sufficient to cause the individual to provide unsafe patient care;

(5) Substance abuse when it affects the individual's ability to perform appropriately as a health care provide or in the patient care environment;

(6) Falsification of credentials;

(7) Falsification of medical records or prescriptions;

(8) Theft of drugs;

(9) Inappropriate prescription of drugs;

(10) Unethical behavior;

(11) Patient abuse, including mental, physical, sexual, and verbal abuse, and including any action or behavior that conflicts with a patient's rights identified in 38 USC 7462; intentional omission of care; willful violations of a patient's privacy; willful physical injury; or intimidation, harassment or ridicule of a patient;

(12) Falsification of research findings.

6. **Automatic Suspension of Privileges**: An Automatic Suspension occurs immediately, upon the occurrence of specific events.

a. The medical staff membership and clinical privileges of any Practitioner with delineated clinical privileges shall be automatically suspended if any of the following occurs:

(1) The Practitioner is being investigated, indicted or convicted of a misdemeanor or felony that could impact the quality and safety of patients.

(2) Failure on the part of any staff member to complete medical records in accordance with system policy will result in progressive disciplinary action to possible indefinite suspension.

(3) The Practitioner is being investigated for fraudulent use of the Government credit card.

(4) Failure to maintain the mandatory requirements for membership to the medical staff.

(5) Loss of a specific credential required for a specific privilege will result in the immediate loss of that specific privilege with 30 workdays to renew the credential. Failure to obtain the credential to perform that privilege after 30 days will result in a loss of that privilege until the provider is re-credentialed.

b. The Chief of Staff convenes the PSB to investigate the matter and make a report thereof to the MEB within fourteen (14) days after the effective date of the Automatic Suspension.

c. Immediately upon the occurrence of an Automatic Suspension, the Service Chief or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.

d. If there are more than three automatic suspensions of privileges in one calendar year, or more than 20 days of automatic suspension in one calendar year, a thorough assessment of the need for the Practitioner's services must be performed and documented and appropriate action taken.

7. **Actions Not Constituting Corrective Action**: The PSB will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:

a. The appointment of an ad hoc investigation committee;

b. The conduct of an investigation into any matter;

c. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview or conference before the Credentials Committee, any ad hoc investigating committee, the Chief of Staff, or any other committee or sub-committee with appropriate jurisdiction in connection with any investigation prior to a proposed adverse recommendation or action;

d. The failure to obtain or maintain any other mandatory requirement for Medical Staff membership;

e. The imposition of proctoring or observation on a Medical Staff member which does not restrict clinical privileges or the delivery of professional services to patients;

f. The issuance of a letter of warning, admonition, or reprimand;

g. Corrective counseling;

h. A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education; or

i. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.

8. Failure to maintain current licensure:

a. Expiration of all licensures or loss of any licensure for cause will result in immediate separation of employment according to VHA Handbook 5005/12, Part II, Chapter 3, dated 8/12/05, Handbook 5021, Part VI, and VHA Handbook 1100.19. Facility employees whose separations are approved by the facility Director, have the right to seek a post-separation or post- cancellation review of the action by the Network Director. The appointment of an individual who does not fully meet all statutory and regulatory requirements at the time of appointment will be cancelled immediately upon discovery of the disqualification.

b. Care of suspended individual's patients: Immediately upon the imposition of a suspension the appropriate Service Chief, or, in his/her absence, the Chief of Staff, shall assign to another individual, with appropriate clinical privileges, responsibility for care of the suspended individual's patients (both inpatients and outpatients). The wishes of the patient shall be

considered in the selection of a provider. It shall be the duty of the Chief of Staff and the Service Chief to cooperate with the Director in enforcing all suspensions.

ARTICLE X. FAIR HEARING AND APPELLATE REVIEW

1. **Reduction of Privileges:**

a. Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

(1) A description of the reason(s) for the change.

(2) A statement of the Practitioner‘s right to be represented by counsel or a representative of the individual’s choice, throughout the proceedings.

b. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff’s written notice of intent. The Practitioner must submit a response within l0 workdays of the Chief of Staff’s written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed l0 additional workdays except in extraordinary circumstances.

c. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the Practitioner disagrees with the Director’s decision, a hearing may be requested. The Practitioner must submit the request for a hearing within five (5) workdays after receipt of decision of the Director.

2. **Convening a Panel**: The facility Director must appoint a review panel of three unbiased professionals, within 5 workdays after receipt of the Practitioner's request for hearing. These three professionals will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

a. The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.

b. During such hearing, the Practitioner has the right to:

(1) Be present throughout the evidentiary proceedings.

(2) Be represented by an attorney or other representative of the Practitioner's choice. ***NOTE:*** *If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses.*

(3) Cross-examine witnesses.

NOTE: *The Practitioner has the right to purchase a copy of the transcript or tape of the hearing.*

3. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.

4. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.

a. The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

b. The facility Director must issue a written decision within 10 workdays of the date of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.

c. If the Practitioner wishes to appeal the Director's decision, the Practitioner may appeal to the appropriate VISN Director within 5 workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

d. The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the Practitioner's appeal.

NOTE: *The decision of the VISN Director is not subject to further appeal.*

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) Conduct argument by counsel on procedural points and do so 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. Practitioner Rights:

(1) The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

(2) The panel will complete its review and submit its report within 15 workdays of the date of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.

(3) The Director will issue a written decision within l0 workdays of the day of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.

(4) The Practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.

(5) The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the Practitioner's appeal. The decision of the VISN Director is not subject to further appeal.

(6) A Practitioner who does not request a review panel hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN Director within five workdays after receipt of the Director's decision.

(7) The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.

(8) If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, if greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

5. **Revocation of Privileges**:

a. Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures.

(1) In instances where revocation of privileges is proposed for permanent employees, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations.

(2) For probationary employees appointed under 38 U.S.C. 7401(1) and 38 U.S.C. 7405, the proposed revocation will be combined with probationary separation procedures, which constitutes an automatic revocation as contained in VA Handbook 5021 Employee/Management Relations.

b. Revocation procedures will be conducted in a timely fashion. If discharge, separation during probation, or termination of appointment is not proposed, revocation of clinical privileges may not occur. Even though a revocation of privileges requires removal from both employment and appointment to the medical staff, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. For example a surgeon's privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

6. **Reporting to the National Practitioner Data Bank**[2]:

a. Tort ("malpractice") claims are filed against the United States government, not individual Practitioners. There is no direct financial liability for named or involved Practitioners. Government attorneys (Regional Counsel, General Counsel, U.S. Attorney) investigate the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.

b. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioners should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.

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[2] Reference VHA Handbook 1100.17.

c. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist regional and general counsel in defending the case and in decisions concerning denial or settlement.

d. Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff's case when a tort claim settlement is submitted for review.

e. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physicians and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4. The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension if greater than 30 days will be reported.

7. **Reporting to State Licensing Boards**: VA has a responsibility to report to state licensing boards appointed or suspended members of the Medical Staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

8. **Management Authority:** Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

9. Where the actions of a licensed trainee warrant reporting, but did not result from gross negligence or willful professional misconduct, the attending is to be reported without mention of an involved trainee, but with a notification that the attending is being reported in a supervisory capacity. In circumstances where the Review Panel concludes that the payment of a claim was related to substandard care, professional incompetence, or professional misconduct resulting from gross negligence or willful professional misconduct on the part of a licensed trainee in a training or residency program, the trainee must be reported to the NPDB (the attending is not

reported). Unlicensed trainees are not to be reported. For further information, please refer to VHA Handbook 1100.17.

ARTICLE XI. RULES AND REGULATIONS

As may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to identify the level of clinical practice that is required of each member of the Medical Staff and of all others with delineated clinical privileges or practicing under a Scope of Practice, Medical Staff Rules and Regulations may be adopted. Rules and Regulations may be adopted, amended, repealed or added by a majority vote of the members of the MEB present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. Medical Staff Rules and Regulations must be approved by the Director.

ARTICLE XII. AMENDMENTS

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from MEB. Changes to the Bylaws are amended, adopted and voted on by the Organized Medical Staff as a whole and then approved by the Director. The Bylaws are amended and adopted by two-thirds endorsement of the active medical staff. If a quorum is not present at a regular or called meeting of the Medical Staff, the Chief of Staff shall direct the MEB to act upon the proposed significant changes that have been published. A quorum of the MEB to act upon these changes is 2/3 of the voting membership of the committee. The document will then be sent to the Governing Council for action and to the Director. Upon approval, these changes will be adopted and made active.

2. The Executive Committee may provisionally adopt and the Director may provisionally approve urgent amendments to the Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the medical staff. After adoption, these urgent amendments to the Rules and Regulations will be immediately communicated back to the Organized Medical Staff for retrospective review and moment on the provisional amendment. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Resolution and Management process noted in Article III, Section 3.05 should be followed.

3. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.

4. All changes to the Bylaws require action by both the Organized Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.

5. Changes are effective when approved by the Director.

ARTICLE XIII. ADOPTION

These Bylaws shall be adopted upon recommendation of the voting-eligible medical staff at any regular or special meeting of the active Medical Staff at which a quorum is present or by a 2/3 vote of a quorum at a Medical Executive Board meeting, shall be recommended by the Governing Council, shall replace any previous Bylaws and shall become effective when approved by the Director.

If the voting members of the organized medical staff propose to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the Executive Committee. If the Executive Committee proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the medical staff. When the Executive Committee adopts a policy or amendment thereto, it must communicate this to the medical staff.

Adopted by the Medical Staff of the VA Tennessee Valley Healthcare System, on March 27, 2015.

Recommended:

//s// 4/20/15

Roger C. Jones, M.D., FACP **Date**

Chief of Staff Approved:

//s// 4/20/15

Juan A. Morales, RN, MSN **Date**

Health System Director