

**BYLAWS AND RULES of THE MEDICAL STAFF Of
Veterans Health Administration (VHA)**

**G. V. (SONNY) MONTGOMERY VA MEDICAL CENTER, JACKSON,
MISSISSIPPI**

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PREAMBLE

Whereas, G. V. (Sonny) Montgomery VA Medical Center (VAMC), Jackson, Mississippi, is a public medical center organized under the provisions of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA).

Whereas, its purpose is to provide acute hospital care, ambulatory care, behavioral health programs, home care and Community Living Center care to eligible beneficiaries, education, and research; and recognizing that the Medical Staff is responsible for the quality of care, treatment, & services delivered by practitioners credentialed and privileged through the Medical Staff process and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the VAMC, Jackson, Mississippi, hereby organize themselves for self-governance in conformity with the laws, regulations, and policies governing VHA and the Bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing VA and do not create any rights or liabilities not otherwise provided for in law or VA Regulations. These Bylaws, rules, and regulations create a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence.

DEFINITIONS

1. **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 facility. Both VA employees and contractors may receive appointments to the Medical Staff.
2. **Automatic Suspension of Privileges.** Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation of clinical concerns. Examples of acceptable justifications of automatic suspension are listed in Article IX, section 9.02. Reactivation must be endorsed by the CEB and approved by the Facility Director.
3. **Center Director.** The Center Director (Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the medical center. The Center Director is assisted by the Chief of Staff, Clinical Executive Board and the Associate Director
4. **Clinical Executive Board (CEB).** This board serves and acts for the Medical Staff in intervals between Medical Staff meetings as defined in Article V, Section 5.02. This board is composed of members as defined in Article V, Section 5.02, with the Chief of Staff as chairperson.
5. **Deans Committee.** Committee established by a formal memorandum of affiliation between this medical center and medical and dental schools of the University of Mississippi, and approved by the Under Secretary for Health; composed of deans and senior faculty members of the University's medical and dental schools, representatives of the medical/dental staff of the medical center; and such other faculty of the University's schools and staff of the facility, including the Nurse Executive, as appropriate, to consider and advise on development, management, and evaluation of all VAMC educational programs conducted at the facility.

6. **Gender.** Any reference to gender in these Bylaws and Rules, "he" or "she" shall be applicable to both sexes.
7. **Governing Body.** The term "Governing Body" refers to the Under Secretary for Health, the individual to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the VA Medical Center Director.
8. **Medical Center Management.** Consists of the Center Director; Chief of Staff; Associate Director; Associate Director of Patient Care Services and other administrative staff members as may be required and requested by the Center Director.
9. **Medical Staff.** All physicians, dentists, and other fully licensed individuals permitted by law and the medical center to provide patient care services independently, that is, without supervision or direction. The Medical Staff is organized under three categories of membership known as the Active, Adjunct, and Affiliate Medical Staff.
 - A. **Active** members are those physicians, dentists, psychologists, and podiatrists who are appointed at least half time or more to the medical center.
 - B. **Adjunct** members are those appointment to the medical center is less than half time; as well as WOC, fee basis, contract, consultants and attendings.
 - C. **Affiliate** members are licensed practitioners other than physicians, dentists, psychologists, and podiatrists who are appointed under these Bylaws; i.e., non-voting practitioners, such as certified registered nurse anesthetists and nurse practitioners. The privileging process is used for affiliate members due to the scope and complexity of their clinical activities.
10. **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
11. **Practitioner.** Any physician with an unlimited license, appropriately licensed dentist, or other appropriately licensed individual who provides patient care services independently; that is, without supervision.
12. **Professional Standards Board (PSB).** This board is composed of physicians or other members of the Medical Staff as appropriate appointed by the Chief of Staff, and the Chief of Staff will serve as chairperson. The PSB reviews competency assessment, quality improvement/performance improvement data process, along with the practitioner's request for privileges. It also conducts special reviews assigned by the Chief of Staff (COS).
13. **Psychology Professional Standards Board (PPSB).** A board composed of three psychologists who hold clinical privileges for independent practice at this Medical Center will serve as a PPSB for reviewing competency for psychology practice along with the psychologist's request for privileges. The chief Psychologist serves as an ex officio member of the PPSB for these reviews. The results are forwarded to the PSB along with the service

chief's recommendation for granting of privileges.

- 14 **Rules.** Refers to the specific rules set forth in this document, which govern the Medical Staff of the medical center. It does not refer to formally promulgated VA Regulations.
- 15 **Verification.** Verification is defined as primary source documentation by letter, telephone call, computer printout, or in the case of confirmation of board certification, by listing in specific Directories. (See VHA policies on credentialing and privileging of physicians and dentists, and VA Directive 5021.)

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi.

ARTICLE II. PURPOSE

- 1 The purpose of the Medical Staff is to develop, approve, and amend as necessary Medical Staff by-laws and rules, and to:
- 2 Ensure that every patient admitted to or treated by any service of this medical center shall receive safe, efficient, timely, and appropriate care, treatment, and services that is subjected to continuous quality improvement practices.
- 3 Ensure that all patients being treated for the same health problem or with the same methods/procedures receive the same level of care.
- 4 Establish and ensure adherence to ethical standards of professional practice and conduct.
- 5 Ensure ongoing evaluation of the competency of practitioners who are privileged, delineate the scope of privileges that will be granted to practitioners, and provide leadership in performance improvement activities within the organization.
- 6 Select and remove Medical Staff officers.
- 7 Determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges.
- 8 Provide an appropriate research and educational setting which will maintain scientific standards; lead to continuous advancement in professional knowledge and skills; and which will relate to patient needs, care provided, and the findings of quality care review activities.
- 9 Bring the deliberations of the Medical Staff to the Center Director and the Governing body.
- 10 Develop and adhere to specific facility mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
- 11 Approve and amend the Medical Staff Bylaws and provide oversight for the quality of care, treatment, and services provided by practitioners with privileges.

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

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, psychologists, and podiatrists who continuously meet the qualifications, standards, and requirements of VHA, this medical center, and these Bylaws. Membership may be considered for other licensed practitioners who are permitted by law to provide patient care services independently and who meet the qualifications, standards, and requirements of VHA, this medical center, and these Bylaws.
2. **Categories of Medical Staff membership include:**
 - A. **Active:** Physicians, dentists, psychologists, and podiatrists on a full-time, temporary full-time, and regular part-time (one-half time or more).
 - B. **Adjunct:** Consultants, attendings, WOC, regular part-time (less than one-half time), intermittent and on-station fee-basis, contract, and sharing agreement physicians, dentists, psychologists, and podiatrists. Fee-basis staff shall be appointed to provide a specific service or perform a specific procedure for the purpose of administering to a particular patient. He will not be eligible to vote or be appointed as a committee member of the Clinical Executive Board.
 - C. **Affiliate:** Licensed practitioners other than physicians, dentists, psychologists, and podiatrists who are appointed under these Bylaws; i.e., non-voting practitioners, such as certified registered nurse anesthetists and nurse practitioners. The credentialing and privileging process is used for affiliate members due to the scope and complexity of their clinical activities.
3. Decisions regarding Medical Staff membership are made without discrimination based on race, creed, 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, 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

To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence of:

1. Picture ID
2. 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. Individuals not licensed to practice in any state or the District of Columbia may be appointed members under the provisions of 38

USC 7407. The Under Secretary for Health or his designee may waive the licensure requirements of an individual solely in research or academic activities or in other positions where there is no direct responsibility for patient care. Psychologists may be given appointments as VA employees for up to two years prior to obtaining licensure. Unlicensed psychologists providing clinical services will work under the supervision of the licensed psychologists with clinical privileges and will not be granted privileges or membership in the Medical Staff.

3. Appropriate education; i.e., hold a Doctoral Degree in the discipline in which the individual is licensed to practice from an approved college or university.
4. Relevant training and/or experience, consistent with the individual's professional assignment and privileges for which applying. This includes any internships, residencies, board certification, or specialty training.
5. Current competence, consistent with the individual's assignment and the privileges for which he is applying. This process may include an assessment for proficiency in the six areas of general competencies (see section 3.03).
6. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within the clinical privileges granted.
7. Complete information consistent with requirements for application and clinical privileges as defined in Article VII or VIII these Bylaws for a position for which the medical center has the patient care need, adequate facilities, support services, and staff.
8. Satisfactory findings relative to previous professional competence and professional conduct.
9. English language proficiency.
10. Current professional liability insurance as required by Federal and VA acquisition regulations (for those individuals providing service under contract).
11. Ability to meet response time criteria established for the service or position for which he is applying.
12. 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) Psychologists
 - iv) Podiatrists

B. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of a State license/registration that permits independent practice as authorized by this Facility:

i) Advanced Practice Nurses

C. 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.

i) Advanced Practice Nurses

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

i) Physician Assistants

NOTE: Individuals appointed to the medical center whose duties are administrative in nature only, with no clinical duties, are subject to the regular personnel policies of the medical center. Those whose duties are administrative and include clinical responsibilities with the Medical Staff must obtain clinical privileges by the same procedure as provided in these Medical Staff Bylaws.

Section 3.03 Core Competencies

Experience, ability, and current competence in performing the requested privilege(s) are verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment, for proficiency in the following six areas of "general competencies"

1. Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
2. Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
3. Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
4. Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
5. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

6. **Systems-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

Section 3.04 Basic Responsibilities, Ethics and Ethical Relationships

The organized Medical Staff (and others with individual clinical privileges) are accountable for and have responsibility to:

1. Provide for continuous care of patients assigned to their care.
2. Observe patients' rights in all patient care activities and consider their psychosocial, cultural, and religious preferences when providing care.
3. Provide oversight in the process of analyzing and improving patient satisfaction.
4. Provide leadership role in organization performance improvement and patient safety activities.
 - A. To ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the Medical Staff provides leadership and is actively involved in the measurement, assessment, and improvement of, but not limited to, the following:
 - i) Use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process.
 - ii) Medical assessment and treatment of patients
 - iii) Use of medications
 - iv) Use of blood and blood components
 - v) Use of operative and other procedures
 - vi) Appropriateness of clinical practice patterns
 - vii) Significant departure from established patterns of clinical practice through peer review
 - viii) Use of developed criteria for autopsies
 - B. To ensure that the Medical Staff participates in the measurement, assessment, and improvement of other patient care processes including, but not limited to the following:
 - i) Education of patients and families.
 - ii) Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient
 - ii) Accurate, timely and legible completion of patient's medical records.
 - C. To ensure that when the finding of the assessment process are relevant to an individual's performance, the Medical Staff is responsible for determining their use in peer review or the ongoing evaluation of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges.
 - D. To ensure that the findings, conclusions, recommendations, and actions taken to improve

organizational performance are communicated to appropriate Medical Staff members. This information will include sentinel event data and other patient safety data as appropriate.

5. Maintain standards of ethics and ethical relationships including a commitment to:
 - A. Abide by Federal Law and VA Rules and Regulations regarding financial conflict of interest and outside professional activities for remuneration.
 - B. Provide care to patients within the scope of privileges and advise the 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.
 - C. Advise the 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 VII of these Bylaws.
 - D. Contribute to and abide by high standards of ethics in professional practice and conduct.
6. Enforces and complies with the Medical Staff Bylaws and Rules and all other lawful standards and policies of the medical center and Veterans Health Administration.
7. No full-time VA members of the Medical Staff may render professional service for remuneration to any patient hospitalized or treated at VA expense in a non-VA hospital, clinic, or other health facility. A full-time staff who engages in outside professional activities for remuneration must scrupulously avoid creating any situation or circumstances where it might be implied that the employee, because of his outside activity, is not meeting the full requirements and responsibilities of his VA position. Consequently, VA staff members who engage in outside professional activities for remuneration will be required to:
 - A. Perform a scheduled tour of duty of 80 hours per pay period while so involved.
 - B. Meet other patient care needs, which require their attendance beyond the scheduled tour of duty.
8. Be responsible for planning and implementing a privileging process.

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. The Medical Staff shall elect a President, Vice President, and Secretary from among active members of the Medical Staff. The individuals will serve a term of 2 years. Any active member of the Medical Staff, who has been a member for a minimum of two years, will be eligible to hold office. Nominations for the positions will come from a nominating committee composed of the current officers of the Medical Staff, and elected at large members of CEB, or from open nominations from the floor prior to the election process.

Elections for the positions will be held at the quarterly meeting of the Medical Staff, which falls closest to the conclusion of the term of office of the sitting officers.

2. At the completion of the president's term, the vice president shall succeed to the president in office. The secretary shall likewise succeed the vice president. Should an officer leave office prior to the end of his/her term, the subordinate officer shall advance and assume the completion of the term of that office, and a special election held to fill the term of the advancing officer. This would allow for the smooth transition of Medical Staff leadership, provide continuity of experience, and encourage a closer working relationship between the officers.
3. Elected officers of the Medical Staff may be removed from office by:
 - A. Failure to maintain membership of the active Medical Staff
 - B. By two-thirds majority vote of the Medical Staff for failure to fulfill his/her responsibilities, malfeasance in office, physical and mental infirmity to a degree which renders him/her incapable of fulfilling the duties or conduct detrimental to the medical center.

Section 4.02 Leadership

1. The President of the Medical Staff, or his designee, will act as Chairperson at all regular or special meetings of the full Medical Staff.
2. The active Medical Staff shall elect four at-large members to the Clinical Executive Board by written ballot every two years. All active Medical Staff members are eligible for membership on the CEB as a representative at large. Each at-large member of the Medical Staff may be removed from office by:
 - A. Failure to maintain membership of the active staff.
 - B. By a 2/3 majority vote of the Medical Staff for failure to fulfill his/her responsibilities, malfeasance in office, physical or mental infirmity to a degree which renders him/her incapable of fulfilling the duties of his/her office, or conduct detrimental to the Medical Staff.
3. The Medical Staff, through its officers, committees, services, and service chiefs, provides counsel and assistance to the Chief of Staff and Center Director regarding all facets of the patient care services program; including performance improvement, goals, plans, mission, and services offered.

Section 4.03 Clinical Services

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:
 - A. Evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.
 - B. Recommendations by the UMC departmental Chairperson will be considered, where

applicable.

2. The 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.
3. A Professional Standards Board (PSB) will be held within 30 days of receipt of all verified information. The PSB is a subcommittee of the Clinical Executive Board (CEB). The Board is composed of five members, one of whom is the Chief of Staff who serves as Chair. The PSB will review the applicant's credentials and will recommend approval/disapproval of Medical Staff membership.
4. Application for Medical Staff membership will normally be acted on by the CEB during the first board meeting following receipt of recommendations of the PSB. Based upon CEB recommendations, the Center Director will appoint or reject the applicant. Due process of rejected applicants is provided in accordance with Federal Regulations as outlined in VA Directive 5977 Equal Employment Opportunity Discrimination Complaints Process.
5. Appointments to the Medical Staff should be acted upon by the Center Director within 45 days of receipt of a complete application including all required verifications, references and recommendations from the appropriate service chief, PSB, and CEB.
6. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment within 10 days of an action by the Center Director. In the case that appointment is not approved, reasons will be provided.
7. Temporary Appointments and Privileges in Emergency Situations:
 - A. The recommendation for temporary privileges will be made by the COS and approved by the Center Director. Temporary privileges should not exceed 60 calendar days.
 - B. To appointment and privileging, verification of the following must be made:
 - Current Licensure
 - Relevant training or experience
 - Current competence
 - Ability to perform the privileges requested
 - Other criteria required by the organized Medical Staff Bylaws
 - A query and evaluation of the NPDB information
 - A complete application
 - No current or previously successful challenge to licensure or registration
 - No subjection to involuntary termination of Medical Staff membership at another organization
 - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
8. Emergency Privileges During Disasters:

- A. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, privileges may be granted by the Chief of Staff and/or the Center Director or their designee(s). Utilizing direct observations and record reviews with standardized triggers, the professional performance/competency of volunteer providers granted disaster privileges will be monitored and overseen by the Medical Staff. Individuals granted emergency privileges during times of disaster will be identified through the hospital identification program. Privileges will be granted on a case-by-case basis after presentation 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:
- A current picture hospital identification card that clearly identifies professional designation
 - A current license to practice.
 - Primary source verification of the license begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. **NOTE:** In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or groups.
 - 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).
 - Identification by a current hospital or Medical Staff members(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during the time of a disaster.
- B. The Chief of Staff and/or the Center Director or their designee(s) will decide within 72 hours if the disaster privileges initially granted a practitioner will continue. The decision will be based on information obtained regarding the profession practice of the volunteer.
- C. Disaster privileges will not exceed 10 calendar days or the length of the disaster, whichever is shorter. At the end of this period, the practitioner will be converted to temporary privileges or relieved.
9. Expedited Appointment: The Credentialing process for an expedited appointment cannot begin until the licensed independent provider completes the credentials package including but not limited to a complete application; therefore the provider must submit this information through VetPro and documentation of credentials must also be retained in VetPro. **Note: VetPro is VHAs electronic credentialing system and must be used for credentialing all**

providers who are granted clinical privileges or credentialed for other reasons.

To expedite the appointment of a provider, the Credentialing and Privileging Section must verify all of the education and training, one active current unrestricted license verified by primary source., current comparable privileges held in another institution, confirm two peer references, confirm the declaration of health, query *NPDB-HIPDB*, query *FSMB*, and have the executive of the clinical service, or care line approval.

- A. An applicant is ineligible for the expedited process if at the time of appointment any of the following has occurred:
- i) The applicant submits an incomplete application;
 - ii) The Clinical Executive Board makes a final recommendation that is adverse or with limitation
 - iii) There is a current challenge or a previously successful challenge to licensure or registration;
 - iv) The applicant has received an involuntary termination of Medical Staff membership at another organization;
 - v) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;
 - vi) There has been a final judgment adverse to the applicant in a professional liability action.
- B. If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted, and there is no history of malpractice payment, the delegated Professional Standard Board may recommend appointment to the Medical Staff. This recommendation, by the Professional Standard Board, will be acted upon by the Medical Center Director. Full credentialing must be completed within 30 workdays and presented to the Clinical Executive Board for ratification. This is a one-time appointment process for initial appointment to the Medical Staff and may not exceed 45 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 45 calendar days of the Expedited Appointment or the Medical Staff appointment is automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director even though ratification of the appointment is accomplished within 45 calendar days (the effective date does not change).

Section 4.04 Professional Services

1. Organization and Characteristics of Services

- A. The Center Director is responsible for the proper and efficient management of the hospital.
- B. The Chief of Staff is directly responsible to the Center Director for the direction and coordination of patient care, and for research and education activities of the hospital.
- C. Each service shall be organized as a component of the staff as a whole and carry out services under the leadership of a service chief that will be responsible to the Chief of Staff for the functioning of his service.

D. The staff of each service shall meet at least every other month, but such meetings shall not release members from their obligation to attend general meetings as provided in Article V of these Bylaws. The staff of each service will participate in prioritization of performance improvement activities, evaluating data, and developing and accessing actions which will be reported in staff meetings and followed up as necessary. Minutes of these meetings will be forwarded to each staff member and the Chief of Staff for review by the CEB. Attendance is required at monthly meetings by all regularly scheduled physicians on the service unless excused for justifiable cause by the service chief.

2. Clinical Services

A. Bed Services:

- i) Medical Service
- ii) Surgical Service
- iii) Neurology Service
- iv) Mental Health Product Line

B. Other Services:

- i) Anesthesiology Service
- ii) Dental Service
- iii) Pathology & Laboratory Medicine Service
- iv) Office of Education
- v) Nursing Service
- vi) Prosthetics and Sensory Aids Service
- vii) Radiation Therapy Service
- viii) Radiology Service
- ix) Physical Medicine & Rehabilitation Service

3. Ambulatory Care

The Chief, Medical Service is responsible for the direct supervision of the admissions office functions. The Chief of Staff will be responsible for the administrative components of the ambulatory care program, including fee services, compensation and pension examinations, and employee health. Service chiefs are responsible for the operation of their outpatient clinics.

4. Community Living Center Care

The Nursing Home Care Program is under the general clinical supervision of the Chief of Staff and the direct supervision of an assigned staff physician. Administrative and professional activities in the area are carried out by an interdisciplinary team.

5. Home Care

The Home Care Program is under the general clinical supervision of the Chief, Medical Service and the direct clinical supervision of assigned staff physicians. The program includes home based primary care and durable medical equipment which includes home oxygen. Administrative and professional activities in each program are carried out by interdisciplinary team.

6. Functions of Services

- A. Provide for continuous quality improvement within the service, including: considering findings of ongoing monitoring and evaluation of quality (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 initiatives; risk management activities; and utilization management.
- B. Assist in identification of important aspects of care for the service, identification of indicators used to monitor quality and appropriateness of important aspects of care, and evaluation of the quality and appropriateness of care.
- C. Maintain records of meetings that include conclusions, recommendations, actions taken, and evaluation of the effectiveness of actions taken.
- D. Develop criteria for and recommend to the Medical Staff clinical privileges for each member of its department.
- E. Define/develop clinical privileges statements including levels or categories of care that are to be provided.
- F. Develop policies and procedures to assure effective management, ethics, safety, and communications within the service.

7. Selection and Appointment of Service Chiefs

Service chiefs are appointed by VA Central Office on the recommendation of the Center Director. The Center Director will seek recommendation from the Chief of Staff. Board certification or certification of competence is required for service chiefs.

8. Duties and Responsibilities of Service Chiefs

- A. In addition to the functions of his service (see paragraph 6 above), service chiefs are *responsible and accountable for*:
 - i) All clinically related activities of the service.
 - ii) All administratively related activities of the service, unless otherwise provided by the medical center.
 - iii) The integration of the service into the primary functions of the organization.
 - iv) The coordination and integration of interdepartmental and intradepartmental services.
 - v) The development and implementation of policies and procedures that guide and

- support the provision of care treatment and services.
- vi) The recommendations for a sufficient number of qualified and competent persons to provide treatment care/service.
 - vii) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the service.
 - viii) Recommending to the Medical Staff the criteria for clinical privileges in the service.
 - ix) Recommending clinical privileges for each member of the service.
 - x) The determination of the qualifications and competence of service personnel who are not licensed independent practitioners and who provide patient care service.
 - xi) The continuous assessment and improvement of the quality of care and services provided.
 - xii) The maintenance of quality control programs, as appropriate.
 - xiii) The orientation and continuing education of all persons in the service.
 - xiv) Recommendations for space and other resources needed by the service.
 - xv) The service chief's assessment and recommendations to the relevant medical center authority off-site sources for needed patient care services not provided by the service or the organization.
 - xvi) Enforcement of the Medical Staff Bylaws and other rules and regulations required by VA.
 - xvii) Implementation, within his service, of actions taken by the CEB and other policies presented by the medical center and/or VA.
 - xviii) Supervision and support of education and research programs within his service.
 - ixx) Representing the interest of VA in affiliated educational and research programs.
 - xx) Assessing and recommending to the governing body off-site sources of needed patient care, treatment, and services not provided by the department.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

All facility committees and committee members shall be appointed by the Center Director in accordance with VA Regulations and as outlined and defined in M-1, Part I, Chapter 1, Change 16 and Medical Center Policy EBGB 00-00 Executive Board of Governing Body.

Section 5.02 Executive Committee of the Medical Staff

1. Membership. The CEB is chaired by the Chief of Staff and is composed of the following:

- A. President of the Medical Staff
- B. Bed Service Chiefs (Medical, Surgical, Neurology and Mental Health)
- C. Chief, Dental Service
- D. Chief, Psychology Service
- E. Chief, Pathology & Laboratory Medicine Service
- F. Members-at-Large (4) (to be elected from & by the active Medical Staff members, to serve for a 2 year period)
- G. Associate Director of Patient Care Services - Ex-Officio, non-voting
- H. Center Director - or Designee, Ex-Officio, non-voting.**

- I. Nurse Practitioner – Ex-officio, non-voting (to be elected by NP members of the Medical Staff)
- J. AA/Chief of Staff - Ex-Officio, non-voting
- K. Chief, Office of Quality Management - Ex-Officio, non-voting
- L. Patient Safety Manager, Ex-Officio, non-voting
- M. Coordinator, Credentialing & Privileging, Ex-officio, non-voting

****** When the CEB is considering a recommendation on the reduction or revocation of clinical privileges, the Director should recuse him or herself from the discussion as the Director is the deciding official in such situations.

******* Joint Commission specifies that the majority of the voting Medical Staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital.

2. Functions. The CEB functions as an authorized Executive Committee of the Medical Staff. It serves and acts on behalf of the organized Medical Staff between Medical Staff meetings. The CEB reports to and is accountable to the organized Medical Staff and the Executive Board of the Governing Body (EBGB). The CEB had the primary authority for activities related to self-governance of the Medical Staff, for performance of the professional services provided by licensed independent practitioners and other practitioners privileged through the Medical Staff process, and quality oversight of measurement, assessment and improvement of all areas mandated by Joint Commission and VHA policy.

- A. Coordinates the medical activities of the medical center; evaluates the quality of patient care services provided by the Medical Staff; and recommends necessary policies and procedures to the Center Director to assure compliance with appropriate professional standards of medical care, applicable VA regulations and Joint Commission requirements.
- B. Receives and acts on reports and recommendations from Medical Staff and hospital committees or services and functions under its purview. The CEB initiates appropriate follow-up actions.
- C. Acts on behalf of the Medical Staff between Medical Staff meetings.
- D. Acts to ensure effective communication between the Medical Staff and the Center Director.
- E. Independently makes recommendations directly to the Executive Board of the Governing Body (EBGB) regarding the:
 - i) Structure of Medical Staff.
 - ii) Mechanisms used to review credentials and delineate clinical privileges.
 - iii) Recommendation of individuals for Medical Staff membership.
 - iv) Delineation of privileges of each practitioner privileged through the Medical Staff process
 - v) Recommendations for delineated clinical privileges for each eligible individual.
 - vi) Receives acts on, and approves reports and recommendations from Medical Staff

- committees, clinical departments, and assigned activity groups.
 - vii) Organization of quality improvement activities of the Medical Staff as well as mechanism used to conduct, evaluate, and revise such activities.
 - viii) Termination actions will be conducted in accord with VHA requirements as specified in VA Directive 5021 "Employee/Management Relations."
 - ix) Mechanisms for fair-hearings procedures as outlined in Directive 5021 "Employee/Management Relations."
 - x) Medical Staff ethics and self-governance actions.
- F. Receives, acts on, and approves criteria for credentialing and granting clinical privileges for each service.
- G. Requests and reviews evaluations of practitioners privileged through the Medical Staff process instances where there is doubt about an applicant's ability to perform the privileges requested.

Section 5.03 Committees of the Medical Staff

1. **Professional Standards Boards (PSB)** The PSB is a subcommittee of the CEB. It reviews applications for appointment and all other personnel applications requiring an appraisal of professional qualifications and performance. It also conducts special reviews assigned by the Chief of Staff or Center Director. (VHA Human Resources 5000 series.)

A. Membership

- i. The Chief of Staff serves as the Chairman. (non-voting)
- ii. Voting members rotate off the committee every two months and consist of three (3) service chiefs and three (3) members selected from the elected medical staff officers of the CEB.
- iii. COS appoints replacement for members unable to attend.
- iv. When non-physician applications are reviewed, representations from the appropriate profession are required (nonvoting).
- v. Other members of the CEB may attend in a nonvoting capacity.

B. Quorum: A quorum consists of four voting members.

C. Meetings

- i. Meetings are regularly scheduled every two weeks.
- ii. Emergency meetings may be called at any time by the COS.
- iii. Agenda for the regular meetings will be distributed to the entire CEB membership one week in advance; additions to the agenda will be distributed one day before the meeting.
- iv. Emergency meeting agendas will be provided prior to the meeting.

D. Decisions of the committee.

Decisions of the committee regarding initial staff applications, re-appraisals and re-privileging will normally be submitted directly to the Center Director for final

disposition; however, if any voting member of the PSB, attending CEB Member, or the COS has concerns regarding an application, the application will be sent to the CEB for its disposition which will then be sent to the Center Director.

E. Reduction of privileges.

Recommendations regarding reduction of privileges or revocation of privileges of staff membership must be sent to the CEB. Triggers already in place identifying cases to be sent for CMO review will also trigger an automatic referral to the CEB.

2. **Standing Committees.** Appropriate committees will be established to ensure accomplishment of the mandatory functional reviews described in M-1, Part I, Chapter 1.85. The following committees and boards are mandatory:

- A. Clinical Executive Board
- B. Professional Standards Board
- C. Resident Review Board
- D. Utilization Review
- E. Clinical Applications Resource Group (CARG) performs medical records committee function
- F. Pharmacy and Therapeutics
- G. Blood Usage Review
- H. Operative and Invasive Procedure
- I. Infection Control
- J. Research and Development
- K. Education
- L. Cancer
- M. Safety, Occupational Health, & Fire Protection
- N. Ethics
- O. Disaster Planning
- P. Intensive Care Unit Committees

Section 5.04 Committee Records and Minutes

Committees prepare and maintain reports of actions taken to improve performance. The effectiveness of actions taken is evaluated. These reports are to be forwarded in a timely manner, normally within two weeks of the meeting. Committees will provide for timely feedback to appropriate services any information for their use.

Section 5.05 Committee Attendance

Medical Staff members, or their designated alternates, will attend meetings of committees of which they are members unless specifically excused by the committee chairperson for appropriate reasons; e.g., illness, leave, clinical requirements, etc. Committee minutes will specify members present.

ARTICLE VI. MEDICAL STAFF MEETINGS

Section 6.01 Medical Staff Meetings

1. Quarterly meetings of the Medical Staff will be held at the call of the President of the Medical Staff. The agenda shall consist of medical and business portions.
2. Special meetings may be called at any time by the Center Director, Chief of Staff, or President of the Medical Staff. The President of the Medical Staff, within five days after receipt of a written request for same, signed by not less than 12½% of the Medical Staff and stating the purpose of such meeting, shall set a date for a special meeting. The President of the Medical Staff shall designate the time and place of any special meeting. Notice of the special meeting, including its date, time, and location, shall be delivered either personally or by mail (electronic or campus) to each member of the Medical Staff not less than 10 days prior to the meeting date. No business shall be transacted at any special meeting, except that stated in the notice calling the meeting.
3. Attendance is mandatory at service staff meetings and committees of which the individual is a member, as accepted below. Medical Staff members will attend at least one meeting of the Medical Staff as a whole, annually, unless specifically excused by the chairperson.
 - A. Except when: specifically excused by the service chief or Chief of Staff for appropriate reasons; e.g., illness, leave, or emergency clinical requirements.
 - B. All meetings of the Medical Staff will be open to active and adjunct members.
4. Voting privileges will reside with active members only.
5. A quorum will consist of one-half (1/2) of the members of the active staff.
6. Agenda will include:
 - A. Reports by Medical Staff Committees, as appropriate.
 - B. Quality of Care issues, including opportunities for improvement.
 - C. Such other business as required for the functioning of the Medical Staff.
7. Minutes of all meetings will reflect, at minimum, attendance, issues discussed, conclusions, actions, recommendations, effectiveness of actions taken and follow-up.

Section 6.02 Director's Staff Meeting

The Center Director, in order to maintain communications with both professional and administrative personnel, holds monthly meetings with all chiefs of service.

Section 6.03 Governance Council

The Governance Council will review, monitor, and control necessary actions required to assure

quality of care. The council will assure that all proper actions are taken to comply with the standards required by the Joint Commission.

The council will also review, monitor, and control actions relative to the assessment of the quality of care and findings and recommendations of external surveys performed by the Department of Veterans Affairs and other organizations.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Note: Credentialing and Privileging will be conducted in accordance with VHA Handbook 1100.19 Credentialing and Privileging

Section 7.01 General Provisions

1. All members of the Medical Staff, as defined in Article III, Section 3.01 para. 2 and all non-Medical Staff practitioners who hold clinical privileges will be subjected to full credentials review at the time of initial appointment, appraisal or reappraisal for granting of clinical privileges, and after a break in service of more than 15 workdays as outlined in this Article. Credentials that are subject to change during leaves of absence 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 authorities for these actions are based upon:
 - A. Provisions of 38 U.S.C. in accordance with VHA Human Resources 5000 series. (add Title 5 references if applicable to the individual Medical Staff composition) and applicable Agreement(s) of Affiliation in force at the time of appointment.
 - B. Federal Law authorizing VA to contract for health care services.
3. Probationary Period. Initial and certain other appointments made under Title 38 U.S.C. 7401(1), 7401(3), 5 U.S.C. 3301, are probationary; others may apply. 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. Regularly appointed United States citizen staff members will be granted an initial one or two-year probationary appointment depending upon their professional discipline with career appointment to follow, subject to annual review. Removal from the staff may be only for disciplinary reasons, in accordance with VA Regulations. This tenured status is not applicable to any type of appointment other than full-time permanent.
5. For licensed non-citizen individuals with permanent (immigrant) visas, appointments will be three-year, temporary, renewable once, and subject to annual review VHA Human Resources 5000 series.
6. All service chiefs are appointed by VA Headquarters for an indefinite term.

7. Consultants and attendings are proposed by the respective chief of service to the Deans Committee for concurrence and nomination to the Chief of Staff and Center Director for approval and appointment.
8. Appointment to the Medical Staff may be based on the ability of the medical center to provide adequate facilities and supportive services for the applicant and his/her patients.
9. All members have delineated clinical privileges, which allow them to provide patient care services independently within the scope of their clinical privileges.

Section 7.02 Application Procedures

1. Complete Application. Applicants for appointment to the Medical Staff must submit a complete application. To be complete, applications for appointment must be submitted by the applicant on forms prescribed and approved, and include authorization for release of information pertinent to the applicant and information regarding:

A. Items specified in Article III, Section 3.01, Qualifications for Medical Staff Membership:

- i. Active, current, full, and unrestricted license
- ii. Education
 - (a) Curriculum vitae - delineate all professional education and work experience
 - (b) Relevant training and/or experience
 - (c) Current competence
- iii. Physical examination and mental health status
- iv. Response time from residence (for on-call responsibility)
- v. English language proficiency
- vi. Contract Medical Staff Members must possess professional liability insurance.

- B. U.S. Citizenship. Applicant must be a citizen 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 documentation of employment authorization (from Immigration and Naturalization Service), pursuant to qualifications as outlined in 38 U.S.C. 7405 and VHA Human Resources 5000 series.

- C. References. Names and addresses of a minimum of three (3) individuals who are qualified to provide authoritative information regarding training/experience, competence, health status, and/or fulfillment of obligations as a Medical Staff member within the privileges requested. At least one of the references must be from the current or most recent employer(s) or institution(s) where clinical privileges are/were held. In the case of individuals completing residencies, one reference must come from the residency program Director.

- D. Previous Employment. A list of all health care institutions where the practitioner is/has been appointed, utilized, or employed, including:

- i. Name of health care institution or practice,

- ii. Term of appointment or employment, and
- iii. Privileges held and any disciplinary actions taken against the privileges, including suspension, revocation, limitations, or voluntary surrender.

E. DEA (Drug Enforcement Administration) registration

- i. Of those who have, or have had, DEA registration.
- ii. Previously successful or currently pending challenges to DEA registration or the voluntary relinquishment of such registration.

F. Challenges to license, including whether a license or registration ever held to practice a health occupation by the practitioner has been suspended, revoked, voluntarily surrendered, or not renewed.

G. Status of any claims made against the practitioner in the practice of any health occupation, as a minimum, final judgments or settlements of professional liability actions must be disclosed.

H. 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. Previous or pending challenges against the practitioner by any hospital, licensing board, law enforcement agency, professional group, or society.

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

K. Approval from Headquarters, if applicable.

2. Documents required in addition to those listed above include:

A. Picture ID – (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). NOTE: The approved picture ID must be viewed again on the day they first report to duty.

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.

D. For foreign medical graduates, evidence and verification of the Educational Commission for Foreign Medical Graduates (ECFMG) certificate.

E. Evidence and verification of board certification, if claimed.

F. Verification of education credentials used to qualify for appointment (and privileges)

including all postgraduate training.

- G. Reports of queries to the National Practitioner Data Bank (NPDB), for all members of the Medical Staff and those practitioners with clinical privileges.
 - H. Confirmation of health status.
 - I. Results of review of the OIG Sanction List (also known as HSS Cautionary List)
 - J. A signed statement that the applicant will abide by the Medical Staff Bylaws and Rules, medical center policies, and VA regulations that apply to his activities and to provide continuous care for his patients.
3. 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 may serve as a basis for denial of employment consideration.

Section 7.03 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:
 - A. Evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.
 - B. Recommendations by the UMC departmental Chairperson will be considered, where applicable.
- 2. The 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.
- 3. A Professional Standards Board (PSB), which is a subcommittee of the CEB, will review applications within 30 days of receipt of all verified information. The PSB will recommend approval/disapproval of medical staff membership.
- 4. The PSB recommendation will be sent either to the CEB for review or directly to the Center Director at the discretion of the PSB (cf. Section 5.03 paragraph 1), if the application is referred to the CEB, it will be acted upon in the first possible scheduled meeting of the CEB or in an emergency meeting in cases requiring urgent action. Based upon those CEB recommendations, the Center Director will appoint or reject applicant. Due process of rejected applicants is provided in accordance with Federal Regulations as outlined in VA Directive 5977 Equal Employment Opportunity Discrimination Complaints Process.
- 5. Appointments to the Medical Staff should be acted upon by the Center Director within 45 days of receipt of a complete application including all required verifications, references and recommendations from the appropriate service chief, PSB, and CEB.

6. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment within 10 days of an action by the Center Director. In the case that appointment is not approved, reasons will be provided.
7. Temporary Appointments and Privileges in Emergency Situations:
 - A. The recommendation for temporary privileges will be made by the COS and approved by the Center Director. Temporary privileges should not exceed 60 calendar days.
 - B. Prior to appointment and privileging, verification of the following must be made:
 - Current Licensure
 - Relevant training or experience
 - Current competence
 - Ability to perform the privileges requested
 - Other criteria required by the organized Medical Staff Bylaws
 - A query and evaluation of the NPDB information
 - A complete application
 - No current or previously successful challenge to licensure or registration
 - No subjection to involuntary termination of Medical Staff membership at another organization
 - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
8. Emergency Privileges During Disasters:
 - A. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, privileges may be granted by the Chief of Staff and/or the Center Director or their designee(s). Utilizing direct observations and record reviews with standardized triggers, the professional performance of volunteer providers granted disaster privileges will be monitored and overseen by the Medical Staff. Individuals granted emergency privileges during times of disaster will be identified through the hospital identification program. Privileges will be granted on a case-by-case basis after presentation 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:

The Chief of Staff and/or the Center Director or their designee(s) will decide within

 - A current picture hospital identification card that clearly identifies professional designation.
 - A current license to practice.
 - Primary source verification of the license begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.

NOTE: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is

expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or groups..
 - 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).
 - Identification by current hospital or Medical Staff members(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.
- B. 72 hours if the disaster privileges initially granted a practitioner will continue. The decision will be based on information obtained regarding the profession practice of the volunteer.
- C. Disaster privileges will not exceed 10 calendar days or the length of the disaster, whichever is shorter. At the end of this period, the practitioner will be converted to temporary privileges or relieved.
9. Expedited Appointment: The Credentialing process for an expedited appointment cannot begin until the licensed independent provider completes the credentials package including but not limited to a complete application, therefore the provider must submit this information through VetPro and documentation of credentials must also be retained in VetPro. Note: VetPro is VHAs electronic credentialing system and must be used for credentialing all providers who are granted clinical privileges or credentialed for other reasons.

To expedite the appointment of a provider, the Credentialing and Privileging Section must verify all of the education and training, one active current unrestricted license verified by primary source., current comparable privileges held in another institution, confirm two peer references, confirm the declaration of health, query *NPDB-HIPDB*, query *FSMB*, and have the executive of the clinical service, or care line approval.

- A. An applicant is ineligible for the expedited process if at the time of appointment any of the following has occurred:
- i. The applicant submits an incomplete application;
 - ii. The Clinical Executive Board makes a final recommendation that is adverse or with limitation
 - iii. There is a current challenge or a previously successful challenge to licensure or registration;
 - iv. The applicant has received an involuntary termination of Medical Staff membership at another organization;
 - v. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;

- vi. There has been a final judgment adverse to the applicant in a professional liability action.

10. If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted, and there is no history of malpractice payment, the delegated Professional Standard Board may recommend appointment to the Medical Staff. This recommendation, by the Professional Standard Board, will be acted upon by the Medical Center Director. Full credentialing must be completed within 30 workdays and presented to the Clinical Executive Board for ratification. This is a one-time appointment process for initial appointment to the Medical Staff and may not exceed 45 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 45 calendar days of the Expedited Appointment or the Medical Staff appointment is automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director even though ratification of the appointment is accomplished within 45 calendar days (the effective date does not change).

Section 7.04 Credentials Evaluation and Maintenance

1. The service chief has the responsibility to ensure each Medical Staff member assigned to his service practices within the scope of privileges granted. Clinical privileges will be reviewed and approved biennially by the service chief, CEB, Chief of Staff, and Center Director.
2. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible or from a credentials verification organization (CVO) the following information:
 - A. The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration.
 - B. The applicant's relevant training.
 - C. The applicant's current competence
3. When it is not possible to obtain information from the primary source, reliable secondary Sources may be used. Designated secondary sources include but are not limited to the following:
 - A. The American Medical Association (AMA) Physician Master file for verification of a physician's United States and Puerto Rican medical school graduation and residency completion.
 - B. The American board of Medical Specialties (ABMS) for verification of a physician's board certification.
 - C. The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school.
 - D. The American Osteopathic Association (AOA) Physician Database for pre-doctoral

education accredited by the AOA Bureau of Professional Education; postdoctoral education approved by the AOA Council on Postdoctoral Training; and Osteopathic Specialty Board Certification.

- E. The Federation of State Medical Boards (FSMB) for all actions against a physician's medical license.
 - F. The American Academy of Physician Assistants (AAPA) Profile for physician assistant education and National Certification Commission (NCCPA) certification.
 - G. The American Nurses Credentialing Center (ANCC) for verification of a nurse practitioner's certification.
- 4. Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff performance improvement indicators) 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. This process may include an assessment for proficiency in the areas of general competencies defined in Article VII.
 - 5. Any new credentials claimed by the practitioner will be verified per Article VIII, Section 8.02, Paragraph 2. Efforts will be made to verify, with primary sources, all credentials claimed.
 - 6. A Credentialing and Privileging Folder will be established and maintained for each practitioner requesting privileges. These folders will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging. At any time that a folder is found to lack required documentation for any reason, effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be 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.
 - 7. Ongoing Professional Practice Evaluation. Each practitioner will have an ongoing assessment review of his activities, conducted by clinical supervisor; which includes information relative to the individual's professional performance, judgment, clinical skills, and, when appropriate, technical skills. Assessment is ongoing with annual review with providers. Other review parameters should include the individual's maintenance of timely, accurate, and complete Medical Staff records; involvement in Performance Improvement activities; attendance at required staff and departmental meetings; service or medical center committees; consideration of practitioner's health status; and patterns of care as demonstrated by reviews and evaluations conducted by committees such as, Medical Records, Utilization Review, etc. A review of the practitioner's participation in continuing education will also be included. Findings will be documented by his clinical supervisor on VA Proficiency Form 10-2623 or the appropriate form for the professional discipline. Additionally, specific provider profile data will be aggregated and submitted to appropriate service chiefs every 6 months. This form will be shown to the practitioner and initialed or signed by him to document his review of it. The completed form will be forwarded to the Chief of Staff for his review and endorsement. Unsatisfactory ratings will be processed in accordance with VA Regulations. Any staff member not satisfied with his review will be afforded the opportunity

to reply and appear before an appropriate board.

8. **Focused Professional Practice Evaluation.** Focused professional practice evaluation is a process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance. Time periods for evaluation will vary depending upon the privilege requested and/or the circumstances that result in questionable patient care.

The organized Medical Staff does the following:

- A. Evaluates practitioners without current performance documentation at the organization.
- B. Evaluates practitioners in response to concerns regarding the provision of safe, high quality patient care.
- C. Develops criteria for extending the evaluation period.
- D. Communicates to the appropriate parties the evaluation results and recommendations based on results.
- E. Implements changes to improve performance.
- F. Ongoing and focused practice evaluations are protected documents under the Privacy Act.

ARTICLE VIII. CLINICAL PRIVILESGES

Note: Credentialing and Privileging will be conducted in accordance with VHA Handbook 1100.19 Credentialing and Privileging.

Section 8.01 General Provisions

- 1 Medical Center specific privileges are granted for a period of two years.
- 2 The Medical Center shall confer on the appointee only such clinical privileges/enhancement/modifications as specified. Privileges granted to an applicant must be hospital-specific, have necessary resources, equipment, space, and personnel available to support the requested privilege, based on the procedures and types of services that are provided within this medical center and deemed needed by the Chief of Staff and Center Director.
- 3 Patient care activities of personnel in the following categories provide patient care services independently and require that their authority for specified services be processed through the Medical Staff. Accordingly, the CEB will approve clinical privileges requested for individuals in these categories:

Physician
Dentist

Certified Registered Nurse Anesthetist
Psychologist
Podiatrist
Nurse Practitioner

4. Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link. The Medical Staff shall determine which clinical services are appropriately delivered through this medium. This determination will be discussed and documented at the CEB. Others professional disciplines may practice telemedicine through a scope of practice. If a member of the Medical Staff proposes, by telemedicine, to prescribe, render a diagnosis, or otherwise provide clinical treatment to a patient, he/she will be credentialed and privileged through the Medical Staff mechanism set forth in these Bylaws.
5. Ongoing assessment and biennial reappraisal of each Medical Staff member and any other practitioner who holds clinical privileges is required. Reappraisal includes a review of performance, current competency, an evaluation of the individual's physical and mental status, and assessment of the individual's current privileges. It also requires documentation of satisfactory completion of 16 hours or documented AMA Category I or II continuing education or the professional equivalent. Evidence of formal documentation may be requested of the provider. Reappraisal is initiated by the practitioner's service chief at the time of a request by the practitioner for new and renewed clinical privileges.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. 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 may serve as a basis for denial of employment consideration.
2. Every initial application for staff appointment must contain a request for privileges from the practitioner with the recommendations of the chief of the service for which he applied. The request for initial clinical privileges must be made in writing and include privileges requested within well-defined limits in a form approved by the CEB and accompany a complete application for privileges which will include:
 - A. Complete appointment information as outlined in Section 7.02 of Article VII.
 - B. Application for clinical privileges as outlined in Section 8.02 para. 2 of this Article.
3. The practitioner applying for clinical privileges subsequent to those granted initially will provide the following information:
 - A. An application for clinical privileges as outlined in Section 8.02 of this Article. (Since practice, techniques, and facility missions' change over time, it is expected that

modifications, additions, or deletions to existing clinical privileges will occur. Practitioners are encouraged to consider carefully and discuss appropriateness of specific privileges with the appropriate service chief prior to formal submission of the request.)

- B. Supporting documentation of professional training and/or experience not previously submitted.
 - C. 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 CEB.
 - D. Documentation of continuing medical education related to the area and scope of clinical privileges will be submitted.
 - E. Status of all licenses, certifications held.
 - F. Any sanction(s), final judgments, or settlements 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; 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 copies of the privileges held.
4. Bylaws Receipt and Pledge. Prior to the granting of clinical privileges, Medical Staff members or applicants will pledge, in writing, to provide for continuous care of their patients and will receive a copy of the Bylaws and Rules and agree to abide by the professional obligations therein.
5. Verification.
- A. Verification of credentials prior to granting of initial privileges will be accomplished as described in Article VII, Section 7.03, "Process and Terms of Appointment."
 - B. Before granting subsequent clinical privileges, the Chief of Staff will assure that the following information is on file and verified with primary sources, as applicable:
 - i. Current and former licenses in all states.
 - ii. Current and former DEA license and/or registration.
 - iii. National Practitioner Data Bank query.
 - iv. Physical and mental health status information from applicant.
 - v. Physical and mental health status confirmation and professional competence information from peers, service chief.
 - vi. Continuing education to meet any local requirements for privileges requested.
 - vii. Board certification(s).
 - viii. Quality of care information.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

1. Renewal of clinical privileges will be conducted biennially and is based on ongoing

professional practice evaluation of the individual as defined in Section 3 of this article.
Renewal of Clinical privileges will include the following:

- A. Evaluation of practitioner specific information as outlined in center policy CPM F-11Q-48 *Medical Staff Professional Practice Evaluations & Performance Profiles*, core competencies, and peer recommendation(s), including service chief recommendation(s).
- B. Verification of current medical licensure and Drug Enforcement Administration (DEA) registration, if applicable; information on health status, professional performance, judgment, and clinical/technical skills, as indicated in part by the results of performance improvement activities; previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration; and voluntary or involuntary termination of Medical Staff membership; or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and other reasonable indicators of continuing qualifications.
- C. The practitioner shall submit any reasonable evidence of current health status that may be required by the CEB.
- D. Actions on renewals or revisions of clinical privileges will be reviewed by PSB within 30 days. Recommendations of the PSB will be sent either directly to the Center Director or to the CEB at the discretion of the PSB. If an application is sent to the CEB, it must be acted upon at the first regularly scheduled meeting or in an emergency meeting in cases requiring urgent action. The candidate and service chief will be notified of the action within 10 days of signature by the Center Director.
- E. Reduction or revocation of clinical privileges will be processed in accordance with VA Regulations and Medical Center Policy (CPM). Material, which is gathered as part of the performance improvement program, may not be disclosed in the course of any action to reduce or revoke privileges. 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.

Section 8.04 Processing an Increase or Modification of Privileges

- 1. Other licensed practitioners who are presently permitted by law and the medical center to provide patient care services independently, will be granted clinical privileges based on their assignments and responsibilities.
- 2. A practitioner's request for modification/enhancement of existing clinical privileges will be made by practitioner submission of a formal request for the desired change(s) with full documentation to support the change.
- 3. Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
- 4. Practitioners with clinical privileges are assigned to and have clinical privileges in one

clinical department/service, but may be granted clinical privileges in other clinical departments/services. Privileges requested from a department/service to which the practitioner is not assigned will be reviewed and recommended according to the established mechanisms for that department/service.

5. Exercise of clinical privileges within any service is subject to the rules of that service and to the authority of that service chief.
6. When certain clinical privileges are contingent upon appointment to the faculty of affiliates, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.

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

1. Peer recommendations will be obtained from individuals who can provide authoritative information regarding training/experience, professional competence and conduct, and health status.
2. The service chief to whose service the applicant for clinical privileges is assigned is responsible for assessing all information and recommending approval of clinical privileges.
 - A. Recommendation for initial privileges will be based on the determination that applicant meets criteria for appointment and clinical privileges for the service including requirements regarding education, training, experience, references, and health status.
 - B. Recommendation for clinical privileges subsequent to those granted initially will be based on, at least, reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical, and/or technical skills, and quality of care including results of monitoring and evaluation activities (such as operative and invasive procedures review, medical record review, blood usage review, and risk management activities.)
3. The CEB recommends granting clinical privileges based on each applicant's successfully meeting the requirements for clinical privileges as specified in these Bylaws.
4. Clinical privileges are acted upon by the Center Director within 45 days of receipt of a complete application for clinical privileges that includes all requirements set forth in Article VII, Section 7.02.
5. Originals of approved clinical privileges documents are placed in the individual practitioner credentialing and privileging folders. A list of procedures performed and staff authorized to perform them will be maintained in the emergency room and intensive care units.

Section 8.06 Exceptions

Emergency Care. Any Medical Staff member is permitted to provide emergency care, within the scope of his license, to any individual whose life, sight, or limb is in immediate danger and delay would place the patient at risk. Therefore, staff, do not have to be granted privileges to perform

those procedures, which are only performed under emergency circumstances. Emergency care may also be provided by properly supervised members of house staff.

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 initial and 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

Section 9.01 Denial of Medical Staff Appointment

1. 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 PSB in a letter over the signature of the Chief of Staff. The notification will briefly state the basis for the action.
2. The Chief of Staff will appoint a board of investigation to conduct a fair hearing within 30 days when requested to do so by individuals who have had an initial request for appointment or privileges denied.

Section 9.02 Request for Investigation

1. 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 the Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical service, the chair of any standing clinical committee, the Chief of Staff, or 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 ground 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 this instance 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. **Fact-finding process.** Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of Article IX, Section 9.02, 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 or misbehavior, or behaviors that undermine a culture of safety, or inappropriate behavior, as defined in these Bylaws, the Director may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the PSB.
3. **Review by the PSB:** The PSB investigates the charges and makes a report of the investigation to the CEB within 14 working 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. **CEB Action.** Within 14 working days after receipt of a report from the PSB the CEB acts 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 the 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 the Bylaws.
 - C. Reduction of privileges may include, but not be limited to functioning under supervision, restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.
 - D. Revocation of privileges refers to the permanent loss of clinical privileges.

5. Summary suspension of privileges. The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, a portion of a practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the 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 CEB within 14 working days after the effective date of the summary suspension.
 - B. Immediately upon the imposition of a summary suspension, the service chief or the chief of staff provides alternate medical coverage for the patients of the suspended practitioner.
6. Automatic suspension of privileges. An automatic suspension is put into effect by the Facility Director and 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 has been indicted or convicted of a felony that could impact the quality of care and safety of patients
 - ii) The practitioner has been indicted or convicted of fraudulent use of the government credit card.
 - iii) Failure to maintain the mandatory licensure requirements for membership on 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 working 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 patient of the suspended practitioner.
 - D. If there are more than three automatic suspensions of privileges in one calendar year, or more than 30 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.
 - E. Re-activation of privileges will be decided by the Facility Director.
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 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

Section 10.01 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 CPM K-11P-60 "Credentialing, Privileging of Independent Practitioners" and CPM F-11P-34 "Reduction or Revocation of Clinical Privileges of Medical or Professional Staff" will be followed.
2. The Center Director may, on the recommendation of the Chief of Staff, summarily suspend Medical Staff Membership or suspend clinical privileges on a temporary basis, pending the outcome of formal action. This action is taken when the Medical Staff member does not possess a valid medical license or when there is sufficient concern regarding patient safety or specific practice patterns consistent with requirements in VHA policy on credentialing and privileging of physicians and dentists to justify this immediate action.
3. Disciplinary and performance based privilege changes (including suspension of an individual's Medical Staff membership and/or clinical privileges, grievances, appeals, and hearings) are undertaken after due process procedures consistent with those outlined in VHA policy on credentialing and privileging of physicians and dentists. In such circumstances, the provider will be afforded the opportunity to review and edit for accuracy any transcript of their own testimony taken in such action. The affected provider will be notified of proposed changes in writing by hand-delivery or registered mail.
4. Reduction of Privileges

- A. Prior to any action or decision by the Director regarding reduction of privileges, the practitioner will receive a written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:
 - i) A description of the reason for the change
 - ii) A statement of the practitioner's right to be represented by counsel or a representative of the individual's choice throughout the proceedings.
 - B. The practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the practitioner may respond in writing to the Chief of Staff's written notice of intent. The practitioner must submit a response within 10 workdays of the Chief of Staff's written notice. If requested by the practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed 10 additional workdays except in extraordinary circumstances.
 - C. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the practitioner disagrees with the Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 workdays after receipt of decision of the Director.
5. 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:
 - i. Be present throughout the evidentiary proceedings.
 - ii. Be represented by an attorney or other representative of the practitioner's choice.
 - iii. Cross-examine witnesses.
6. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.
7. 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 direction 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 administrative appeal.

- 8. 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 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.
- 9. 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-examines witnesses, and to purchase a copy of the transcript or tape of the hearing.

- A. The panel will complete its review and submit its report within 14 workdays of the date of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.
 - B. The Director will issue a written decision within 10 workdays of the day of receipt of the panel's report. If the practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.
 - C. The practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.
 - D. 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 administrative appeal.
 - E. A practitioner who does not request a review panel hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN Director with five workdays after receipt of the Director's decision.
 - F. The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with reduction of privileges; any other review processes will be conducted on the basis of the record.
 - G. If the 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.
10. Revocation of privileges:
- A. Proposed action taken to revoke a practitioner's privileges will be made using VHA procedures.
 - i. In instances where revocation of privileges is proposed for permanent employees, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, US code and VA Handbook 5021 Employee/ Management Relations.
 - ii. For probationary employees appointed under 38 USC 7401(1) and 38 USC 7405, the proposed revocation will be combined with probationary separation procedures,

which constitute 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 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 CEB for the 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 the Bylaws.

11. Reporting to the National Practitioner Data Bank

- A. Tort claims are filed against the United States government, not individual practitioners. There is no direct financial liability for named or involved practitioners. Government attorney (Regional counsel, General Counsel, US 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 licensed practitioner in order to meet t reporting requirements.
- C. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist regional and general counsel in defending the case and in decisions concerning denial or settlement.
- D. Post-payment reviews are performed nationally by the office of medical-legal affairs. Accordingly, a letter may now be sent to physicians involved in the plaintiffs' case when a tort claim settlement is submitted for review.
- E. VA only reports adverse privileging actions that adversely affect the clinical privileges of physician and Dentists after a professional review action or if the practitioner surrenders clinical privileges while under investigation. The professional review action is the due process 9e.g. fair hearing and appeal process0 afforded the practitioner for a reduction or revocation of clinical privileges. The reference for this 38 CVR 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.

12. Reporting to state licensing boards. VA has the 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.
13. 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 of specific practice patterns. Individuals appointed under authority of 38 USC 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.

Section 10.02 Reporting Adverse Actions

1. Disclosure of information to State licensing boards regarding practitioners separated from VA service will be completed in accordance with VA policy.
2. Disclosure of information to the National Practitioner Data Bank (NPDB) through State licensing boards regarding adverse action against clinical privileges of more than 30 days will follow provisions of the VHA policy on NPDB Reporting.

Section 10.03 Reporting Malpractice Payments

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

Section 10.04 Termination of Appointment

Clinical Executive Board (CEB) may recommend Medical Staff membership termination to the governing body. Termination of Medical Staff appointments will be accomplished in conjunction with, and follow procedures for; terminating appointments of practitioners set forth in VHA Human Resources 5000 series.

ARTICLE XI. RULES AND REGULATIONS

1. The Medical Staff shall adopt such rules (not in conflict with the requirements of Federal Law) 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 Center Director. Such rules shall be a part of these Bylaws. They may be amended at any regular or special meeting, without previous notice, by a two-thirds' vote of the members present or by an approved electronic voting mechanism following format presentation at a meeting. Fifty percent of the active staff constitutes a quorum. Such changes shall become effective when approved by the Center Director.

2. Published and numbered Center Policy Memoranda are an extension of the Medical Staff Rules.
3. In cases of a documented need for an urgent amendment to the rules necessary to comply with law or regulation, the Clinical Executive Board may adopt the provisional amendment to the rules that is deemed necessary for legal or regulatory compliance. After adoption, this provisional amendment to the rules will be communicated back to the organized Medical Staff for review within 3 days. The amendment will stand if approved by two-thirds of a quorum of the active Medical Staff present in a Medical Staff meeting or by an approved electronic voting mechanism following formal presentation at a meeting. If the active Medical Staff does not approve the amendment, the amendment will not stand and will be given over to the conflict resolution process if needed. The conflict resolution process will be initiated using VA Directive 5978/1.

ARTICLE XII - AMENDMENTS

1. These Bylaws and all attachments shall be reviewed, revised, and/or amended as necessary to reflect current practices with respect to Medical Staff organization and functions; and shall be dated to indicate the date of last review. Neither the Medical Staff nor the governing body may unilaterally amend the Medical Staff by-laws or rules and regulations.
2. The responsibility for review or revision lies within the office of the Chief of Staff.
 - A. 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 will be notified of the date proposed changes will be considered.
 - B. Proposed amendments to the Bylaws and Rules and attendant policies may be submitted in writing to the Chief of Staff by any service chief or member of the Medical Staff.
3. These Bylaws shall be amended after presentation to members of the Medical Staff. For adoption, any amendment shall require a two-thirds (2/3) vote of those active staff members present or by approved electronic voting.
4. All changes to the Bylaws require action by both the Medical Staff and Center Director. Neither may amend unilaterally.
5. Changes are effective when approved by the Center Director.

ARTICLE XIII - ADOPTION

These Bylaws, with the supporting Rules, shall be adopted upon recommendation of the Medical Staff at any regular or special meeting of the active Medical Staff at which a quorum is present or by an approved electronic voting mechanism following formal presentation at a meeting; shall replace any previous Bylaws and Rules; and shall become effective when approved by the Center Director. The Center Director shall inform the Medical Staff, in writing within 30 days, of his decision not to approve any changes to the Bylaws or Rules of the Medical Staff duly passed by the Medical Staff at a regular or special meeting.

Adopted by the Medical Staff on
(Date)

 /S/

Chief of Staff

Adopted by the Center Director on
(Date)

 /S/

Joe D Battle
Center Director

Revised: 04/11/2014

MEDICAL STAFF RULES

1. GENERAL

- A. PURPOSE.** These Rules relate to the roles and/or responsibilities of members of the Medical Staff which includes individuals with clinical privileges such as psychologists, nurse anesthetists, nurse practitioners, and podiatrists. The Rules apply to the care of inpatients, emergency care patients, and ambulatory care patients as a whole or to specific groups as designated.
- B. SERVICE RULES.** Rules of medical center services will not conflict with these Bylaws and Rules, policies of the Medical Staff, requirements of the Governing Body, or the rules of other services.
- C. MEDICAL CENTER POLICY.** Published and numbered Center Policy Memoranda (CPM) is considered an extension of these Rules and Bylaws. As such, these memoranda shall also guide the Medical Staff in the accomplishment of their duties. They are available to all staff directly, through service chiefs and from the office of the Chief of Staff. They are available to prospective staff for review upon request.
- D. GENDER.** Any reference to gender in these Rules and Bylaws, "he" or "she", shall be applicable to both sexes.

2. PATIENTS' RIGHTS

- A. RIGHTS and RESPONSIBILITIES.** This medical center supports the rights of each patient and addresses those rights prominently in published policies and procedures for both staff and patients; they include:
 - i) **Treatment and Care.** A patient shall be provided equitable and humane treatment, integrated with considerate and respectful care, at all times. He is entitled to a reasonable response to his requests and need for service within the capacity, mission, laws, and regulations, which govern the medical center.
 - ii) **Privacy and Confidentiality.** Every individual who enters this hospital for care retains certain rights for privacy; not only the privacy of his body, but the privacy of disclosure. Therefore, all verbal or written disclosures of facts regarding a patient, other than to the family and authorized VA and congressional inquiries, will be cleared through the Health Information Management Section in Medical Administration Service.
 - iii) **Communication.** The patient has the right to communicate and collaborate with those responsible for his care and to receive from them adequate information concerning the nature and extent of his clinical problem, the planned course of treatment, and the prognosis with consideration to advance directives made by the patient.
 - iv) **Information and Education.** The patient has the right to know the identity of the physician who is primarily responsible for his care and to be informed as to the nature

and purpose of any technical procedures that are to be performed on him, as well as to know by whom such procedures are to be carried out. He shall expect adequate instruction in self-care for the interim between visits to the hospital or to the physician. He has the right to access information necessary to make healthcare decisions that reflect his wishes and to information regarding any human experimentation or research/education projects affecting patient care.

- v) **Representation.** Every patient has the right to participate in or to be represented in the consideration of ethical decisions regarding care or in resolving complaints. A patient may formulate advance directives and appoint a surrogate to make health care decisions in his behalf. A legally authorized person may exercise the patient's rights if the patient is judged incompetent in accordance with law, or is found by the physician to be medically incapable of understanding treatment, or is unable to communicate his wishes.
- vi) **Refusal.** The patient has the right to refuse treatment to the extent permitted by law, to include foregoing or withdrawing life sustaining treatment including resuscitation, and to be informed of the medical consequences of his action.
- vii) **Documentation.** Patient education and informed consent are considered an essential part of the patient's clinical record and should be clearly documented on the patient's chart.

B. PATIENT SELF-DETERMINATION. This Medical Staff and medical center recognizes the patient's right to self-determination in health care decisions and the role of the medical center to assist him in that process. Patients have rights as outlined in State and Federal statutes to execute advance directives. It is the physician's role to provide the necessary medical facts and recommendations to the patient or surrogate decision-maker for his subjective decision concerning treatment based upon their understanding of the facts presented. These concepts are detailed in CPM F-125-20 "Informed Consent for Clinical Treatments and Procedures" and include: informed consent, advance directives, do-not-resuscitate instructions, organ or body donation, surgical, and other invasive procedures performed without blood transfusions or blood products.

3. RESPONSIBILITY FOR CARE

A. CONDUCT of CARE.

- i) The care of each patient shall be the responsibility of a member of the Medical Staff with appropriate privileges. Such staff member shall be responsible for medical or dental care and treatment and for prompt completion and accuracy of the medical record. He shall be responsible for any special instructions regarding the patient and for transmitting, through established medical administrative procedures, reports on patient condition to the referring practitioner and family of the patient. Although the day-to-day treatment of the patient may be delegated to the supervised house staff, the responsibility for patient care rests with the member of the Medical Staff. Whenever these responsibilities are transferred to another staff physician or service, an order covering the transfer shall be entered in the medical record.

- ii) The same level of care (inpatient/outpatient and medical, surgical, dental, anesthesia, and other) shall be applied with the same standard and maintained at a comparable level throughout the medical center.
- iii) The attending physician (inpatient) or primary care provider (outpatient) will be responsible for coordination of care, treatment, and services among the practitioners involved in a patient's care, treatment, and services.

B. DENTAL SERVICES.

- i) A physician member of the Medical Staff must be responsible for the care of any medical problem that may be present or that may arise during the hospitalization of a dental patient.
- ii) Dental surgical privileges must be specifically defined in the same manner as other surgical privileges and may be exercised only under the overall supervision of the Chief, Surgical Service.

C. OTHER LICENSED PRACTITIONERS. Licensed healthcare professionals, other than members of the organized Medical Staff, whose patient care activities require delineation of clinical privileges may render services to patients under the following conditions:

- i) Each individual in this category will present his request for clinical privileges and qualifications for review by the appropriate service. If approved, the governing body may grant such individual privileges.
- ii) They may not admit patients independently.
- iii) Services will be performed only at the request of a member of the Medical Staff who shall be responsible for the patient and his medical records.
- iv) Activities of these individuals will be limited to those defined in their scope of practice approved by their collaborative/consultant physician and approved by the Medical Staff.

D. ADMISSIONS.

- i) Individuals granted the privilege to admit to inpatient services must be physician members of the Medical Staff.
- ii) Except in an emergency, no patient will be admitted to the hospital until after a provisional diagnosis has been stated on the medical record. The hospital shall admit legally eligible patients suffering from any type of disease or injury, which in the opinion of the admitting physician, can be treated at this hospital or should be admitted for humanitarian reasons until such time as the patient may be transferred to a suitable hospital equipped to care for the disease or injury. The Medical Staff members or house officers will promptly examine and make the proper disposition of all applicants eligible for care. Any patient may be admitted for emergency care.

iii) Final authority for admission and assignment to a service rests with the admitting physician and is not subject to rescission by the service receiving the patient. When an admission to a specialty service is considered to be necessary by the admitting physician, the service should be contacted for consultation. If this consultation is not provided within one hour, the patient may be admitted to the service in question by the admitting physician.

iv) Admitting medical assessment of the patient shall include:

a) Medical history including:

- i. Chief complaint
- ii. Details of the present illness including previous clinical observations and results of therapy
- iii. Relevant past, social and family history
- iv. Review of systems, including pain assessment
- v. Summary of the patient's mental status
- vi. Report of relevant physical examinations
- vii. Statement of conclusions or impressions
- viii. Statement of the course of action planned

v) Nursing Service will be responsible for promptly notifying the responsible receiving physician as soon as a new patient has arrived on the ward.

vi) All patients shall be attended by a physician member of the Medical Staff.

vii) H&P (History and Physical) Examination: An H&P examination and tentative diagnosis shall be accomplished and documented by a physician within 24 hours of admission of the patient. The H&P and required updates will be performed by a practitioner who has been granted privileges to do so. Individuals who are not licensed independent practitioners may perform part or all of a patient's H&P under the supervision of or through appropriate delegation by a specific qualified doctor of medicine or osteopathy member of the Medical Staff who is then accountable for the patient's medical H&P as signified by co-signature. If dictated for transcription a brief electronic admission note containing pertinent findings (i.e., enough information for clinicians to manage the patient and guide the plan of care), will be on the chart within 24 hours. Interval notes may be used if a patient is readmitted within 30 days to the same service. Medical Staff admitting patients shall be responsible for prompt completion and accuracy of medical records. Dentists will provide appropriate dental elements of the H&P examination when the patient is admitted for dental care. For non-inpatient procedures, the H&P must be relevant to the specific procedure and must always include a cardiopulmonary exam. This would be in addition to any evaluation that anesthesia would perform.

ix) Tests

a) On admission to the hospital, each patient shall have appropriate laboratory and x-ray examinations. However, there will be no standing or routine orders.

- b) HIV testing will not be conducted without the prior, informed, documented verbal consent of the patient.

E. TRANSFERS.

i) General and Internal

- a) Patients shall not be transferred from one service to another, or out of an ICU or recovery room, without a written order in the chart by the practitioner responsible for his care.
- b) Transfers from one service to another will be accomplished by mutual agreement of the services involved.
- c) All pertinent medical information will accompany the patient. Orders will automatically be canceled on moving from one service to another.
- d) Nursing Service will be responsible for promptly notifying the responsible receiving physician as soon as a new patient has arrived on the ward.

F. External.

- i) No patient who meets eligibility criteria or is in need of emergency or humanitarian care shall be arbitrarily transferred out when this medical center has the means to provide adequate care.
- ii) Each potential transfer to the medical center shall be considered using the criteria of:
 - (a) the medical center to provide appropriate care and (b) the patient's stability to endure a move without detrimental effect.

F. CONSULTATIONS.

- i) **Requirement.** Except in an emergency, consultation with another qualified physician is required when in the judgment of the patient's attending staff member:
 - a) The patient is not a good risk for operation or treatment.
 - b) The diagnosis is obscure.
 - c) There is doubt as to the best therapeutic measures to be recommended and utilized.
 - d) Psychiatric consultations and treatment should be requested and offered to all patients who have attempted suicide or have taken a chemical overdose. That such services were at least ordered must be documented in the patient's medical record.
- ii) **Consultant.** A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical

Staff on the basis of the individual's training, experience, and competency. Resident staff may act as consultants when approved by the service chief and consistent with center policy on resident supervision.

iii) **Essentials.** A satisfactory consultation includes an examination of the patient, his records, and appropriate documentation. When operative procedures are involved, the consultation, except in an emergency, shall be reported prior to the operation.

iv) **Responsibility.**

- a) The service chiefs will assure that members of their staff provide timely consultation, as needed.
- b) The attending physician in conjunction with other members of the health care team will have the final decision as to whether treatment or procedures recommended by the consultant are implemented. There should be documented agreement between the primary treating service and a consultant before a diagnostic or therapeutic procedure is performed.
- c) If agreed, consultants may write orders on patients of another physician or service.
- d) Good medical judgment shall always be exercised in initiation of consultation requests in order to avoid overburdening the consulting section, department, or individual. Consultation should be requested for valid medical or educational reasons.
- e) Medical ethics shall be followed by consultants.

v) **Initiating Requests.** Consultation should be initiated by the attending Medical Staff member or by the house staff. The consultation should be in writing, on the appropriate form, and addressed to a specific service or person. Consultation requests should be written clearly, setting forth the problem and the information requested.

vi) **Response.**

- a) The responsibility of determining policy regarding response to consultation requests, usually within 24 hours for inpatients and 30 days for outpatients, rests with the chief of the clinical service and/or subspecialty section from which consultative support has been requested. The guiding philosophy shall be to provide consultation with a high level of professional competency, efficiency, and promptness, both for service to the patient and for educational purposes. Whenever possible, the clinical staff practitioner will answer the consultation either individually or jointly with the resident. It is recognized that this is difficult within small clinical services and sections. In some instances, advanced, competent residents may respond to consultation requests. The resident responding should be licensed to practice. The person actually examining and writing the consultation advice should affix his signature to the consultation, thus fixing the medical and legal responsibility.

- b) In every instance where the clinician originating the request for consultation specifically requests a particular staff physician or dentist, his request should be honored by the consulting service or section.
- vii) **Nursing Service.** If a nurse has any reason to doubt or question the care provided to any patient and feels that appropriate consultation is needed and has not been obtained, he shall direct such questions to the attending staff member. If, after this, he still feels that the questions have not been resolved, he shall call this to the attention of his supervisor, who, in turn, may refer the matter to the Chief, Nursing Service. The Chief, Nursing Service shall bring the matter to the attention of the appropriate service chief.

G. DISCHARGE.

- i) Patients shall be discharged only on written order of an authorized practitioner. Insofar as possible, discharge orders will be written 24 hours in advance of the contemplated departure of the patient. No discharge will be affected without compliance with provisions of Section 6, Medical Records.
- ii) **Against Medical Advice (AMA).** Should a patient leave the hospital against the advice of the attending staff member or without proper discharge, notation of this incident shall be made in the patient's medical record. An AMA discharge shall be recorded in the patients' record.
- iii) **Missing patient.** When a patient has been declared a "missing patient," policies and procedures in CPM B-136-03, "Management of Wandering and Missing Patients (Inpatients and Outpatients)", will be followed.

H. AUTOPSY

- i) In the interest of improving patient care and professional knowledge, every member of the professional staff is expected to actively participate in securing permission for autopsies in all deaths. Special effort will be made to secure an autopsy when death is unexpected or the cause is in question. The following criteria will be used:
- Sudden and unexpected deaths during hospitalization.
 - Death during or within 24 hours of an invasive procedure.
 - Death of patients on whom a diagnosis was not fully established.
 - Death from nosocomial infection not resolved.
 - Death during trial of new or experimental drugs or therapy.
 - Death in which abuse is suspected.
 - Death under anesthesia.
 - Death following an unscheduled admission from a nursing home.
 - Unexpected postoperative deaths.
 - Patients dying from postoperative complications such as
 - Sepsis, shock, hemorrhage, or vascular disease.
 - Disruption of anastomotic connections.
 - Deaths from Alzheimer's disease or other dementias.
 - Suicide.

-Deaths of patients on multiple pharmaceutical agents.

Consent for autopsies will be obtained by signature of the next-of-kin on the appropriate form, including any limitation imposed by the next-of-kin. Permission for donation of any organ or tissue should be included. The physician staff will provide information regarding clinical diagnosis and concerns to the pathology staff prior to the autopsy, specifically including any infection hazards.

- ii) Autopsy findings shall be included in appropriate performance improvement activities.

4. PHYSICIANS' ORDERS

A. GENERAL REQUIREMENTS.

- i) The nurse shall notify the practitioner in case of doubt. "Renew," "repeat," and "continue" previous orders are not acceptable, unless specifics are included. All previous orders will be automatically canceled when patients go to the operating room or are transferred to another service.
- ii) House staff may write orders for patient care in accordance with the foregoing rules and regulations and center policy on resident supervision.

B. MEDICATION ORDERS.

- i) All Medical Staff will be familiar with current, applicable medical center policy memoranda regarding the prescription, dispensing, and administering of drugs. Administration time or time intervals between doses are required on all prescriptions and medication orders. Compliance with the policies and procedures outlined in those memoranda will be strictly enforced.
- ii) Anticoagulant drugs should be ordered specifically as to dosage, time, and route of administration. The order will be promptly reviewed and acted upon after 3 days.
- iii) Patients bringing their own medications into the hospital shall not have this medication administered unless specifically ordered by the patient's attending physician.

C. Laboratory Orders

- i) Blood drawn for cross-matching in anticipation of blood transfusion shall be placed only in tubes labeled at the time of venipuncture with the patient's name, social security number, date, and initials of two individuals verifying the patient identity against wrist band, as per CPM F-113-01, Blood Transfusion.
- ii) Specimens will be accepted and analyzed only with a valid order by a member of the organized Medical Staff or other persons authorized under law and VHA policy.

D. STANDING ORDERS. There will be no standing or routine orders.

E. AUTOMATIC STOP ORDERS. Automatic stop orders for drugs are described in CPM F-119-6, *Drug Policy*.

F. VERBAL ORDERS. Verbal/telephone orders are limited to emergencies and to circumstances when in the opinion of the physician, having the physician input the orders into the computer would significantly delay necessary medical care of the patient. Verbal orders for the routine admission or discharge process, routine testing, and routine medications are unacceptable.

- i) In the management of emergency circumstances when the urgency of the clinical situation requires verbal orders; e.g., during cardiopulmonary resuscitation.
- ii) When orders are not practical; e.g., when patient interest is best served by verbal order to enhance efficiency of care.
- iii) In all circumstances where verbal orders are given, they may be accepted and transcribed only by registered nurses, registered respiratory therapists, or pharmacists. The full range of authority and restrictions are described CPM F-118-13, *Verbal Ordering Inpatient/Community Living Center Service*. All Medical Staff members will be familiar with this policy and conform to its requirements. Verbal orders, as well as seclusion or restraint (including chemical restraints) and suicide precautions should be written in the chart as soon as possible and authenticated by the practitioner's signature within 24 hours.
- iv) Verbal orders will be written and read back to ensure accuracy.

G. INVESTIGATIONAL DRUGS. May be used only when approved by the Research and Development Committee and the CEB. They will be administered under an approved protocol with patient informed consent and under the supervision of the authorized principal investigator. Approved protocols are not required when investigational drugs are used for humanitarian reasons; however, approval by the Research & Development Committee and CEB is still required.

H. INFORMED CONSENT. Except in specific instances, treatment plan diagnostic and therapeutic endeavors will be undertaken only with the prior informed, voluntary consent on the part of the patient. The principle of informed consent will be uniformly applied as outlined in CPM F-125-20 *Informed Consent for Clinical Treatments and Procedures*.

I. SUBMISSION OF SURGICAL SPECIMENS. All tissue and material removed during an operation shall be sent to the hospital pathologist who shall make such examination, or disposition, as he may consider necessary to arrive at a pathological diagnosis, and he shall sign the report. Bone marrow smears may be interpreted by either specially trained internists or pathologists. The physician's signed report shall be made a part of the patient's medical record as soon as possible. All tissue shall remain the property of the hospital under the custody of the Chief, Pathology & Laboratory Medicine Service.

J. REVIEW OF OUTSIDE PATHOLOGICAL MATERIAL. When patients are scheduled to undergo elective treatment (including surgery, radiation therapy, or chemotherapy) based on tissue samples obtained elsewhere, representative tissue material

must be reviewed by a pathologist at this medical center and the diagnosis confirmed. The elective treatment/procedure should not be performed until confirmation of the diagnosis has been obtained.

K. SPECIAL TREATMENT PROCEDURES.

i) Life Sustaining Treatment.

- a) Cardiopulmonary Resuscitation (CPR) will be administered to patients who sustain cardiopulmonary arrest, except when resuscitation would be futile or useless or when medical records contain advance directives which describe the patient's or surrogate decision-maker's wishes to institute "do not resuscitate" (DNR) orders. Specific policies and procedures regarding the role of the physician, the family, conflict resolution, decision-making mechanisms, and record documentation are outlined in CPM F-123-14 *Cardiopulmonary Arrest – "Code Blue"* and F125-16 *"Do Not Resuscitate" (DNR)*
- b) The center policy and procedures regarding CPR are detailed in CPM F-11 14, Policy for *Cardiopulmonary Arrest – "Code Blue"*. CPM F-123-14 *Cardiopulmonary Arrest – "Code Blue"* All members of the Medical Staff must be familiar with and conform to this policy.

ii) Protective Security.

- Restraint: Any method of physically restricting a person's freedom of movement, physical activity, or normal access to his/her body.
- Seclusion: The involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving, for any period of time.
- a) Care of confused, combative, or emotionally disturbed patients may necessitate the use of restraints. Such measures shall be used only in a protective and therapeutic mode to prevent the patient from causing physical harm to self or others.
- b) The use of mechanical restraints and/or seclusion will be kept to a minimum and used as a last resort, when all other intervention and treatment modalities have failed and are so documented. (See CPM F-118-25, *Restraint and/or Seclusion of Patients*.)
 - 1) A Licensed Independent Practitioner's (LIP) written order will be required for such measures and must specify the length of time, not to exceed four hours, and have basis for use documented in clinical justification.
 - 2) The observation and assessment of patients in seclusion must be documented at intervals no longer than every 15 minutes.
 - 3) In an emergency situation for behavioral health reasons where the LIP is not immediately available, a registered nurse may initiate restraint and seclusion

without the LIP's order, if the nurse has assessed the patient and is qualified by training and experience in the proper use of restraint and seclusion. The LIP must assess the patient within four hours of being placed in restraints.

- 4) In order for an emergent initiated restraint or seclusion to be continued, the LIP must write a specific order and progress note within four hours after the restraint or seclusion initiation. If the patient is no longer in restraints or seclusion when the original verbal order expires, the LIP conducts an in-person evaluation within 24 hours of the initiation of the restraints or seclusion.
 - 5) If the patient is continued in restraint or seclusion more than four hours, reevaluation of the patient will take place every four hours by a designated trained, competent caregiver. A LIP will conduct an in-person reevaluation every eight hours.
 - 6) An LIP's written order will be requested to initiate protocols for medical protective devices employed on acute Medical and Surgical units.
- iii) **Emergency commitment.** In an emergency, any Medical Staff physician may hold a patient for commitment until the next duty day. The physician will immediately notify Police Service and will not leave the patient until they are on the scene. Data for the affidavit for commitment should be recorded immediately, to capture an accurate description of the actual behavior (where, when, how long and names of witnesses who observed facts). These procedures will immediately be coordinated with Mental Health Service. All commitment actions shall be guided by CPM C-136- 03; *Commitment under Mississippi State Laws*.
- iv) **Incident reporting.** The Medical Staff must be sensitive and responsive to the requirements for incident reporting as described in CPM A-00-31, *Reports of Incidents Involving a Patient or Other Beneficiary*. It is the policy of the medical center that all incidents or alleged incidents be reported and adequately reviewed, including an investigation if indicated.
- v) **Multidisciplinary treatment.** When a team approach is used in the treatment of a patient, the areas of responsibility and authority, together with the functional role of the team, should be documented and approved within the service. In every case, even though authority to perform certain acts may be delegated to various team members, the ultimate responsibility for diagnosis and treatment of a patient remains with the physician, and thus the physician must participate in and sign any treatment plan development.

5. ROLE OF ATTENDING STAFF

A. Supervision of Residents.

- i) **Supervision of Residents.** Residents are individuals assigned to the medical center for the primary purpose of receiving post-graduate training and education and who participate in patient care under the direction of VA staff physicians/dentists who

have clinical privileges in the areas supervised. Thus, patient care is an inherent component of their assignments. The scope and degree of their involvement in the care of a patient will be commensurate with their demonstrated knowledge, judgment, and health care skills.

- a) Appropriate supervision includes examination of the patient, discussion of the findings and therapeutic options, development of a plan for medical care, and execution of this plan to completion of the episode of care.
- b) Responsibility for the care of each patient lies with the staff physician/dentist to whom the patient is assigned; and supervision of residents providing care is, likewise, the responsibility of the staff physician. The staff physician will fulfill this responsibility by active participation in the patients' care and by sufficient documentation in the patients' chart to substantiate the participation.
- c) Ultimately the effectiveness of this program rests with first-line supervisors, the service chiefs, and staff physicians who supervise residents. All participants shall be guided by the provisions of VA Handbook 1400.1; Resident Supervision.
- d) A patient care order written by a member of the Medical Staff shall take precedence over an order written by house staff.

B. Documentation of Supervision.

- i) Sufficient evidence will be documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician within 24 hours of admission at the time of any significant change in clinical course or therapeutic plan, prior to any invasive procedure, and critical changes in the patients' condition that may warrant a change in the diagnostic and/or treatment plans. Frequency shall otherwise be guided by the nature of the patient's condition, complexity of the case, the experience of the individual being supervised, and to adequately substantiate the participation.
- ii) Entries in the medical record, made by house staff that requires countersigning by supervisory or attending Medical Staff members are the Discharge Summary, History and Physical Exam, Treatment Plan, and surgical operations reports.
- iii) The CEB will, at intervals, review and approve minutes of the Residency Review Board and monitoring instruments used to evaluate residency supervision.

6. MEDICAL RECORDS

- A. An authorized physician or dentist must collect and record a sufficient database to provide optimal care for each patient. All dental patients must receive the same basic medical appraisal by a physician as patients admitted for other services.
- B. Records will be created and maintained in an acceptable, systematic manner for each patient treated.
- C. Consultant's notes shall be written or typed and shall express a specific opinion relevant

to the patient for the purpose requested. The consultation report should state that the medical record was reviewed by the consultant.

- D.** Nursing and laboratory observations will be included in the medical record, according to published policy.
- E.** Progress of the patient must be recorded at a frequency appropriate to the clinical circumstances of the patient and include physician's evaluation of therapies provided the patient.
- F.** The clinical resume should recapitulate concisely the reason for the hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and the specific instructions given to the patient and/or family, particularly in relation to physical activity, ability to return to work, medication, diet, and follow-up care.
- G.** The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission. This resume is to be prepared before discharge from the hospital, except for AMA and death discharges. The therapy, which the patient received, must be described sufficiently so that another practitioner can assume responsibility for the care at any time without adversity to the patient.
- H.** Respiratory care services must be documented in the patient's medical records in relation to the type of therapy, dates, and times of administrations, specifications of the prescriptions, effects of therapy, including any adverse reactions; and a physician's entry must describe the timely pertinent clinical evaluation and results of therapy.
- I.** The attending staff member or house staff officers shall write onto the medical record of each patient, as soon after admission as possible, the following:
 - i) The provisional diagnosis or recognized problems.
 - ii) An initial progress note stating the cause of hospitalization, his clinical findings, and the course of treatment contemplated.
 - iii) A complete history and physical examination within 24 hours after admission.
Signatures with appropriate title e.g., M.D.
- J.** History and physical examinations, performed by medical students, and dental residents shall be edited, amended as necessary, and countersigned by licensed house staff or attending physician. All entries reflecting medical opinion by medical students or unlicensed house staff must be countersigned by the involved licensed house staff or attending physician.
- K.** The medical record must contain documentation to the effect that a staff person has seen the patient and concurs in the diagnosis and treatment plan. The staff representative must also support his continued supervision of the resident by appropriate documentation on the chart.

- L.** All records are the property of the G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi, and cannot be removed from the premises, except:
- i) When the patient is receiving services elsewhere under this hospital's auspices;
 - ii) Under court order, statute subpoena; or
 - iii) Conditions consistent with VHA Handbook 1907, "Health Information Management and Health Records."
- N.** Free access to all medical records of all patients shall be afforded to Medical Staff for bona fide study and research, which has been approved by the Research and Development Committee (R&D) consistent with preserving the confidentiality of personal information concerning the individual patient, in accordance with the Privacy Act of 1975.
- O.** Medical records will be completed at the time of discharge, including progress notes, diagnosis, and discharge note. All summaries shall be signed by the attending staff member or his designee.
- P.** Discharge summaries, with the exception of AMA and death summaries, must be dictated prior to discharge.
- Q.** Medical records not completed at discharge will be completed within 30 calendar days.
- R.** Medical records for outpatient visits must be completed within one day of the encounters.
- S.** The Medical Records Committee will establish a list of acceptable abbreviations and symbols, and a list of unacceptable dangerous abbreviations not to use in the medical record approved by CEB.
- T.** Provisional (anatomic) autopsy diagnoses must be made part of the patient's medical record within 1 day, and the final/complete necropsy protocol within 30 workdays.
- U.** Individuals approved to document in the medical record are designated in attachment.
- V.** Medical records shall not be permanently filed until they are completed by the Medical Staff member, or his designee, who has knowledge of the patient and his care, or ordered filed by the Medical Record Administrator (according to the procedure outlined by the Medical Records Committee).
- W.** A medical record is determined to be complete when the required contents are assembled and authenticated including any complication, the required clinical resume and final progress note. Completeness implies the transcription of any dictated record content and its insertion into the medical record.
- X.** Staff members, who fail to complete their assignments, including records, will be subject to disciplinary actions according to VA procedure outlined in VHA Human Resources 5000 series.

- Y. Members of the Medical Staff and other practitioners, as determined by the Medical Records Committee, and approved by the CEB, have authority to enter information into the medical record. (See attached list.)

7. INFECTION CONTROL

- A. Infection control practices will be strictly adhered to, as outlined in the Center Infection Control Manual and CPM F-111-23, *Tuberculosis in the Health Care Setting*.
- B. All services must document in-service education relative to infection prevention and control.
- C. There will be a regular review of the clinical use of antibiotics.
- D. The Medical Staff must actively participate in the study of hospital-associated infections and infection potential and must promote a preventive and corrective program designed to minimize those hazards.
- E. The review of patient care shall contain an infection control/isolation area or criteria when pertinent to the monitoring and evaluation.

8. CONTINUING EDUCATION

- A. A program of continuing education must be designed to keep the Medical Staff informed of significant new developments and skills in the health care professions.
- B. Medical Staff education should include hospital based programs, planned, scheduled in advance and held on a continuing basis and educational opportunities held outside the hospital.
- C. Documentation of continuing education activities will be maintained.
- D. Members of the Medical Staff are encouraged to attend continuing educational meetings, conferences, or symposia at the hospital or elsewhere to maintain or upgrade professional skills. The Office of Education will maintain records of continuing medical education for all staff members who are employed half-time or more. Each year, a Continuing Education record form will be sent to such staff members for their completion and return to the education office.
- E. Medical Staff assigned to a particular service must attend their service meetings, unless excused by the service chief.
- F. All orientation and in-service education programs will be specific to the employee's function.
- G. Medical Staff members must have a minimum of 16 American Medical Association Category I, or II or equivalent continuing education hours documented annually.

9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

- A. Medical Staff will receive education on recognizing signs and symptoms of illnesses and impairments, which occur at increased frequency in health professionals at their initial employment and at intervals as necessary.
- B. Referrals of Medical Staff providers with suspected illnesses or impairments by self or others may be made to the appropriate service chief, Employee Assistant Program, or the Chief of Staff.
- C. All referrals will be confidential and may not be used for disciplinary action except as limited by law, ethical obligations, or when to patient safety is threatened.
- D. In circumstances where the credibility of the allegation or concern is sustained, appropriate monitoring of the affected Medical Staff provider's practice will be initiated to assure patient safety until the rehabilitation process is complete and periodically thereafter, if required.
- E. Any findings of unsafe medical care will be reported to Medical Staff leadership.

10. PEER REVIEW

The Medical Staff shall participate in a protected peer review process. A peer review committee is established and appropriate education will be provided to all participants of the protected peer review process prior to participating in a review with refresher training biennially. The protected peer review process is outlined in CPM A-110-41 "Peer Review for Quality Management" and VHA Directive 2010-025 "Peer Review for Quality Management".

11. RULES OF SURGICAL CARE

- A. Major surgical operations, other than emergency, shall not be performed until all adequate clinical and laboratory data are obtained, including physical exam and medical history indicating diagnosis, tests, and determinations of a preoperative diagnosis.
- B. Written, signed informed surgical consent shall be obtained prior to any operative procedure, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving an unconscious patient in whom consent for surgery cannot be immediately obtained from next-of-kin, these circumstances should be fully explained on the patient's medical record. The Chief of Staff must be consulted for his concurrence and has the authority to approve the operation. VA forms and procedures will be used as described in CPM F-125-20, *Informed Consent for Clinical Treatment and Procedures*. In procedures where it is anticipated that blood is likely to be used, patients must receive pre-operative informed consent for the administration of blood and blood products.
- C. In a surgical procedure with unusual hazards to life, there must be a qualified assistant present or immediately available. Medical students should act only in a second, third, or fourth assistant capacity at major operative procedures.

- D. Medical and dental students may be permitted to perform minor surgery such as closure of minor wounds, minor excision of cysts, etc., only when under the direct supervision of a Medical Staff member and with the permission of the patient, with full knowledge that the operator is a student. Records will reflect the true status of the surgical team.
- E. Anesthesiology Service shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthetic follow-up of the patient's condition, both in the recovery room and after his return to the ward.
- F. All surgical operations shall be fully described and recorded immediately by the responsible surgeon or his designee. The operative note shall include the indications for and findings at operations, as pertinent, as well as the technical description of the procedure.
- G. There shall be written guidelines developed by an anesthesiologist for the safe use of all general anesthetic agents used in the hospital. When the operating anesthesia team consists entirely of non-physicians; for example, dentists with nurse anesthetists, a physician must be immediately available in case of emergency such as cardiac standstill or cardiac arrhythmia.
- H. The release of every patient from the post anesthesia care unit must be based on a physician's decision or RNs using approved protocols.
- I. There must be evidence in the medical record of a post anesthesia visit which is made after the patient has left the post anesthesia care unit and describes the presence or absence of anesthesia-related complications. In addition, each post anesthesia note should specify the date and time of the visit.
- J. Post anesthesia care unit medical information should include vital signs, level of consciousness on entering and leaving the recovery area, status of infusion, status of surgical dressings, and status of any tubes, catheters or drains.

12. DISASTERS

Mass casualty assignments for Medical Staff will contain the assignment to posts within the hospital (and off-station triage sites and/or teams), and it is the responsibility of the Medical Staff member to report to his assigned station when needed. The Chief of Staff and Center Director will work as a team to coordinate activities and direction. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises; the Chief of Staff, during the disaster, will authorize movement of patients as directed by the Center Director or his designee. All policies concerning patient care will be the responsibility of the Chief of Staff or Center Director, or in their absences, the Acting Chief of Staff and Associate Director.

13. QUALITY of PROFESSIONAL SERVICE

- A. Ambulatory care services and the Nursing Home Care Unit shall meet the same standards of quality as apply to inpatient care. This standard recognizes the inherent differences

between inpatients, Nursing Home Care Unit residents, and outpatients with respect to their needs and modes of treatment.

- B.** The quality of care provided in the outpatient service will be reviewed and evaluated by the Ambulatory Care Committee.
- C.** Evaluation of the efficiency and effectiveness of ancillary patient services shall be carried out systematically in an objective manner and appropriately documented. Overall responsibility for the quality of medical care rests with the Medical Staff.
- D.** There shall be a program of systematic professional and administrative review and evaluation of each service's effectiveness in relation to its stated mission and objectives.
- E.** The quality of patient care shall be evaluated by members of the Medical Staff and other members of the professional staff directly responsible for patient care. Criteria must be explicit and measurable and must reflect the optimal level of care that can be achieved through current medical and related health science knowledge.
- F.** Variations in the quality of care that are not justified to peer satisfaction must be analyzed. If analysis indicates inappropriate pattern of patient care, action must be taken to correct the problem. Such actions must be specific to the problem and may include educational or training programs, amended policies or procedures, increased or realigned staffing, provision of new equipment or facilities, or adjustments in clinical privileges.
- G.** The entire patient-care evaluation activity must be documented and its results reported. The evaluation activity shall be continuous and shall be comprehensive of conditions and problems treated and procedures performed.
- H.** Members of the Medical Staff are involved in activities to measure, assess, and improve organizational performance through a peer review process as specified in center policy.

14. PERFORMANCE IMPROVEMENT

- A.** The Medical Staff has a leadership role in the performance improvement processes and activities as specified in the medical center Performance Improvement Plan.
- B.** The Medical Staff will be actively involved in measurement assessment and improvement of processes which depend on the activities of one or more licensed independent practitioners in the following areas:
 - i) Medical assessment and treatment of patients
 - ii) Use of information about adverse privileging decisions for a practitioner privileged through the Medical Staff process.
 - iii) Use of medications.
 - iv) Use of blood and blood components.

- v) Operative and other procedures.
 - vi) Appropriateness of clinical practice patterns.
 - vii) Significant departures from established patterns of clinical practice.
 - viii) The use of developed criteria for autopsies.
 - ix) Sentinel event data.
- C.** The Medical Staff will be actively involved in organization wide measurement assessment and improvement of processes which depend on the activities of:
- i) Education of patients and families.
 - ii) Coordination of care, treatment, and services with other practitioners and hospital personnel as relevant to the care, treatment, and services of an individual patient.
 - iii) Accurate, timely, and legible completion of patient's medical records.
 - iv) Findings of the assessment process that is relevant to an individual's performance and determining the use of this information in the ongoing evaluation of a practitioner's competence.
 - v) Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

15. PATIENT SAFETY

- A.** The Medical Staff shall participate in processes and activities that make the care environment safe and effective by reducing and controlling environmental hazards and risks by preventing accidents and injuries, and by maintaining safe conditions for patients, visitors, and staff as specified by published medical center policy memoranda.
- B.** Safety processes include safety management, security management, hazards materials and waste management, medical equipment management and utility systems management as specified in published medical center policy memoranda.

16. PATIENT SATISFACTION

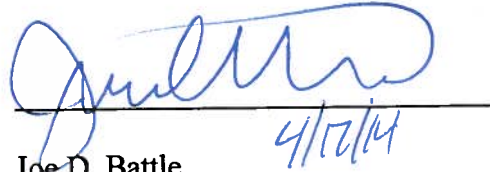
The Medical Staff shall participate in the analysis of patient satisfaction data and the development of processes and activities to improve patient satisfaction. Activities to improve patient satisfaction will be in accordance with the medical center Performance Improvement Plan.

Adopted by the Medical Staff on

A handwritten signature in blue ink, appearing to read "Dil Walker M", written over a horizontal line.

David M. Walker, M.D., MBA
Chief of Staff

Adopted by the Center Director on

A handwritten signature in blue ink, appearing to read "Joe D. Battle", written over a horizontal line. To the right of the signature, the date "4/12/14" is handwritten.

Joe D. Battle
Center Director

Attachment A

INDIVIDUALS/DISCIPLINES APPROVED TO DOCUMENT IN THE MEDICAL RECORD

A&MMS Purchasing Agent
Addiction therapists
American Association of Pastoral Counseling Program
Students Administrative Assistants to Clinical Service Chiefs
Audiologists
Certified Registered Nurse Anesthetists
Staff Chaplains
Chief Prosthetics & Sensory Aids Service
Chiropractors
Contract Program Assistant
Clinical Pastoral Education Program Residents
Cytotechnologist
Dental
Hygienists
Dentists
Diet Technicians
Dietitians
Health Science Specialist
Health Technicians
Licensed Practical Nurses
Medical Administration Service Personnel
(Senior) Medical Students and Nursing Students with co-signature
Medical Support
Assistants Medical
Technician Medical
Technologist
Neuro-diagnostics technologists
Nuclear Medicine Technologists
Nurse Practitioners
Nursing Assistants Occupational
Therapists Occupational
Therapy Assistants
Patient Service Assistants
Pharmacists
Physical Therapists
Physical Therapy
Assistants Physician
Assistants Physicians
Podiatrists
Program Support Assistants
Psychologists

Psychology Technicians
Psychology Interns and Psychology Postdoctoral Fellows with co-signature
Radiology Technicians
Recreational Therapists
Registered Nurses Respiratory Therapists
Social Workers
Social Work students with co-signature
Speech Pathologists
Vocational Counselors