MEDICAL STAFF BYLAWS

AND

MEDICAL STAFF RULES AND REGULATIONS

HARRY S. TRUMAN MEMORIAL VETERANS' HOSPITAL

COLUMBIA, MISSOURI

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MEDICAL STAFF BYLAWS

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BYLAWS AND RULES OF THE MEDICAL STAFF OF THE HARRY S. TRUMAN MEMORIAL VETERANS' HOSPITAL COLUMBIA, MISSOURI

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri, hereby organizes itself for self governance in conformity with the laws, regulations and policies governing Veterans Health Administration (VHA) and the Bylaws and Rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing Department of Veterans Affairs (VA) and they do not create any rights or liabilities not otherwise provided for in laws or VA regulations.

The Harry S. Truman Memorial Veterans' Hospital is a federal institution organized under the laws of the United States of America. Its mission is to improve the health of the veterans we serve by providing primary care, specialty care, extended care and related social support services in an integrated health care delivery system. It provides education and research, and support to the Department of Defense in times of national emergency.

DEFINITIONS

1. HOSPITAL means Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri and associated Community-Based Outpatient Clinics (CBOCs).

2. MEDICAL STAFF or STAFF means the formal organization of all medical physicians and osteopathic physicians holding unlimited licenses, and duly licensed dentists, podiatrists, optometrists, doctoral psychologists, doctoral audiologists, doctoral speech pathologists, and doctoral nurses who possess qualifications identified by VA as necessary to attend patients, provide consultation and teach in the hospital. House Officers (resident physicians) or academic consultants are not included. The Medical Staff is organized under a single category of membership known as the active Medical Staff.

3. GOVERNING BODY refers to the VHA 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 Hospital Director.

4. HOSPITAL DIRECTOR or DIRECTOR means the "Chief Executive Officer" who is appointed by the Governing Body to act as its agent in the overall management of the hospital. The Chief of Staff (with the Clinical Executive Board) and the Associate Director assist the Director.

5. AFFILIATION PARTNERSHIP COUNCIL is chaired by the Dean of the University of Missouri-Columbia School of Medicine. This council is responsible for providing input into strategic planning for the affiliated institutions. Membership on the Affiliation Partnership Council includes deans and senior faculty members of the affiliated institution. Meetings of the Affiliation Partnership Council will be held quarterly and serve as an efficient vehicle to disseminate information to the leadership of both institutions.

6. PRACTITIONER means any member of the Medical Staff applying for or exercising granted clinical privileges in the Hospital and/or at CBOCs.

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

8. TELEMEDICINE is the provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.

9. MEDICAL OFFICER OF THE DAY means a physician in training privileged to work in the Emergency Department without supervision.

10. ADVANCE PRACTICE NURSES AND PHYSICIAN ASSISTANTS are credentialed through VetPro but are not eligible for Medical Staff membership. They function through a scope of practice with a collaborating or supervising physician.

11. APPOINTMENT, as used in this document, 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. VA employees, contractors, WOC and other practitioners in approved categories may receive appointment to the Medical Staff.

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

13. CLINICAL EXECUTIVE BOARD (CEB) means the Executive Committee of the Medical Staff.

14. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to an individual to render specific diagnostic or therapeutic medical, dental, podiatric, surgical, or other patient care services.

15. MEDICAL STAFF YEAR means the period from October 1 to September 30.

16. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

17. SPECIAL NOTICE means written notification.

18. HOUSE STAFF (HOUSE OFFICER) means a licensed physician participating in an approved residency or fellowship program who engages in medical activities under the supervision of a Medical Staff member.

19. EXECUTIVE COMMITTEE OF THE MEDICAL STAFF means the Clinical Executive Board (CEB).

20. VETPRO is the Internet system for credentialing of VHA health care providers that facilitates completion of a uniform, accurate and complete credentials file.

21. RESEARCH PHYSICIAN means a physician without clinical privileges who will not participate in the care/treatment of patient but is required to be credentialed through VetPro.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Harry S. Truman Memorial Veterans' Hospital.

ARTICLE II. PURPOSE

The purpose of the Medical Staff shall be to:

a. Ensure that all patients treated at the Harry S. Truman Memorial Veterans' Hospital on any service will receive efficient, timely, appropriate care that is subject to continuous quality improvement practices.

b. Ensure all patients treated for the same health problem or with the same methods/procedures receive the same level of care.

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

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

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

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

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

h. Bring the dimension of Medical Staff leadership to deliberations by the Hospital Director and the Governing Body.

i. Develop and implement performance improvement activities in collaboration with the facility staff.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Membership Eligibility

a. Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent practitioners who continuously meet the qualifications, standards and requirements of VHA, this Hospital and these Bylaws. Membership may be considered for other licensed health care providers who are permitted by law to provide patient care services independently and who meet the qualifications, standards and requirements of VHA, this Hospital and these Bylaws.

b. Research physicians without clinical responsibilities are credentialed through the standard credentialing process (VetPro) but not granted privileges. These physicians are not members of the Medical Staff.

c. Categories: The Medical Staff shall include clinically active members who assume all the functions and responsibilities of membership on the Medical Staff including, where appropriate, emergency service care and consultation assignments and affiliated members who generally serve in support roles including call coverage. Members of the **clinically** active Medical Staff shall be appointed to a specific service line, shall be eligible to vote and to serve on Medical Staff committees. Clinically active membership requires 200 onsite patient encounters over a two year period. Clinically active members may be in Category I or II below. Affiliated members shall be appointed to a specific service line and may serve on Medical Staff committees, but will not be eligible for voting privileges. Affiliated members may be in Category II or III below. Members of the Medical Staff shall be further sub-classified into the following categories:

1) Category I: Medical Staff members who are employed by the Department of Veterans Affairs on at least a half-time basis or hold official administrative appointments. Unless formally excused, members in this category are required to attend Medical Staff meetings and the staff meetings of the clinical service line to which they are assigned. Physicians who practice off-site at Community-Based Outpatient Clinics (CBOCs) and are appointed on a half time basis or greater are excused from Medical Staff meetings and staff meetings because they provide care at a remote location. They will have the opportunity to vote in absentia and will be provided copies of minutes of all Medical Staff meetings.

2) Category II: This category includes Medical Staff members employed on less than a half time basis. These members are encouraged to attend meetings of the Medical Staff; however, attendance shall not be mandatory because of the intermittent nature of their clinical activities at this Hospital.

3) Category III: This category includes Medical Staff members who are appointed as consultants and attendings, on-station fee basis physicians, contract physicians, without compensation (WOC) physicians, telemedicine physicians, and Medical Officers of the Day. These members are encouraged to attend meetings of the Medical Staff and the clinical service line to which they are assigned. However, attendance shall not be mandatory because of the intermittent nature of their clinical activities at this Hospital.

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

Section 2. Qualifications for Medical Staff Membership and Clinical Privileges

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

a. An active, current, full and unrestricted license to practice their 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.

b. Education applicable to individual Medical Staff members as defined, e.g., hold a degree of Doctor of Medicine, Osteopathy, Dentistry, Podiatry, Optometry, a degree of Ph.D. in Psychology, Speech Pathology or Nursing from an approved college or university.

c. Relevant Training and/or Experience consistent with the individual's professional assignment and privileges for which he/she applies. This includes any internships, residencies, board certification or specialty training. Physician members must be board certifiable in their area of specialty.

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

e. Health Status consistent with physical and mental capability to satisfactorily perform the duties of the Medical Staff assignment within clinical privileges requested.

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

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

h. English Language Proficiency.

i. For those individuals providing service under contracts, current professional liability insurance as required by Federal and VA acquisition regulations.

Section 3. Basic Responsibilities of Medical Staff Membership

Medical Staff members are accountable for and have responsibility to:

a. Provide for continuous care of patients assigned to their care.

b. Observe Patients' Rights in all patient care activities.

c. Participate in continuing education, peer review, Medical Staff monitoring and evaluation.

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

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

2) Provide care to patients within the scope of privileges and advise the Hospital 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.

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

4) Contribute to, and abide by, high standards of ethics in professional practice and conduct.

e. Abide by the Medical Staff Bylaws and Rules and all other lawful standards and policies of the Hospital and Veterans Health Administration.

ARTICLE IV. APPOINTMENT AND INITIAL CREDENTIALING

Section 1. General Provisions

a. All Veterans Health Administration (VHA) physicians, dentists, and other Medical Staff members as defined by the Medical Staff Bylaws are credentialed and privileged. The requirements of The Joint Commission and VHA policies have been used to define the credentialing, privileging, reappraisal/reprivileging, and modification of privilege processes. This process applies to all members of the Medical Staff involved in patient care who are appointed or utilized on a full-time (FT), part-time (PT), intermittent, consultant and attending (C&A), without compensation (WOC), on-station fee-basis, on-station contract or on-station sharing agreement basis.

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

1) Provisions of 38 U.S.C. in accordance with Department of Veterans Affairs Manual MP-5, part II, chapter 2, and its supplements and provisions of 5 U.S.C. in accordance with Department of Veterans Affairs Manual MP-5, part I, chapter 315, and applicable Agreement(s) of Affiliation in force at the time of appointment.

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

c. Probationary Period. Initial and certain other appointments made under 38 U.S.C. 7401(1), 7401(3), and/or 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies and procedures. If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply similar processes to the evaluation of individuals employed under provisions of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.

Section 2. Application Procedures

a. Applicants for appointment to the Medical Staff must submit a complete credentialing application which includes entering credentialing information in VetPro and completing application forms. The application must be on forms approved by the VA and/or the Hospital and include authorization for release of information pertinent to the applicant.

1) The applicant must provide evidence of the items specified in Article III, Section 2, and Qualifications for Medical Staff Membership:

a) Active, current, full and unrestricted license;

b) Education and training;

c) Board certifiable in area of specialty;

d) Current competence;

e) Physical and mental health status;

f) English language proficiency; and

g) Professional liability insurance, if applicable**.**

2) U.S. Citizenship. Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment, with proof of current VISA status and documentation from Immigration and Naturalization Service of employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Manual MP-5, part II, chapter 2.

3) References. Names and addresses of a minimum of three (3) practitioners in the same professional discipline who have personal knowledge of the applicant's ability to practice and 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.

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

a) Name of health care institution or practice;

b) Term of appointment or employment; and

c) Privileges held and any disciplinary actions taken against the privileges, including suspension, voluntary or involuntary limitation, reduction or loss.

5) DEA (Drug Enforcement Administration) registration information including previously successful or currently pending challenges or the voluntary relinquishment of such registration.

6) Challenges to licensure or registration, including suspension, revocation, and voluntary or involuntary relinquishment.

7) Status of any claims made against the practitioner in the practice of any health occupation. NOTE: Final judgments or settlements of professional liability actions are the minimum requirement. This information is reviewed to determine if there is evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant.

8) Voluntary or involuntary termination of Medical Staff membership and/or employment.

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

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

11) Morbidity and mortality data and relevant practitioner-specific data are compared to aggregate data, when available.

b. Applicants are required to provide the following documents in addition to those listed above:

1) Names and addresses for a minimum of three peers able to provide authoritative information regarding the individual's training/experience, professional competence and conduct and health status. At least one of the references must be from the current or most recent employer(s) or institution(s). In the case of individuals completing residencies or other education/training programs, one reference must come from the program director.

2) Names and addresses of institutions at which he/she holds or has held current or recent clinical privileges.

3) A list of licenses (and license status) for all states in which the applicant ever held a license.

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

5) Evidence of board certification, if claimed.

6) Names and addresses of institutions at which he/she trained for the education credentials used to qualify for appointment including all postgraduate training. Applicants are required to provide information on all educational and training experiences including all gaps of more than 30 days in educational history.

7) Signed Declaration of Health.

8) Agreement to abide by the Bylaws and Rules, and to provide continuous patient care.

c. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of professional competence, character, ethics and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information in a timely manner may serve as a basis for denial of consideration for employment and medical staff membership.

Section 3. Credentialing

a. General Provisions

1) Individuals are fully credentialed prior to initial appointment or reappointment after a break in service of more than 15 workdays.

2) Credentialing is the systematic process of verifying and reviewing the qualifications and the health status of applicants to ensure that they possess the required education, training, experience, physical and mental health, and skill to fulfill the requirements of

the position. This section contains the administrative requirements and procedures related to the initial credentialing and reappraisal of practitioners who plan to apply for clinical privileges.

3) The credentialing process includes the use of VetPro to obtain verification, through the appropriate primary source, of the individual's professional education, training, licensure, review of health status, previous experience, any gaps greater than 30 days in training and employment, clinical privileges, professional references, certifications, malpractice history, and adverse actions or criminal violations, as appropriate. Employment commitments are not made until applicants are properly screened through the appropriate state licensing boards and the Office of the Inspector General's Exclusions Database. Medical Staff members are also screened through the Federation of State Medical Boards (FSMB) and registered with National Practitioner Data Bank-Health (NPDB)-Health Integrity and Protection Data Bank (HIPDB) Proactive Disclosure Service (PDS). Individuals reappointed after a break in service of more than 15 workdays are screened again through the appropriate state licensing boards, the Exclusions Database, and the FSMB and NPDB-HIPDB, as appropriate. All information obtained through the credentialing process is carefully considered before an appointment decision is made.

b. Verification of Educational/Training Credentials

1) Written verification of all of the applicants' education and training is obtained from the primary source. Primary source verification of other advanced educational/clinical practice programs is required if a Medical Staff member offers that training as primary support for specialized clinical privileges. Any fees charged by institutions to verify education credentials are to be paid by the facility.

2) For international medical school graduates, written verification that the applicant has met requirements for certification with the Educational Commission for Foreign Medical Graduates (ECFMG) is obtained. The ECFMG is not applicable for graduates from Canadian or Puerto Rican medical schools. Verification of completion of a "Fifth Pathway" may be substituted for ECFMG certification. In accordance with The Joint Commission standards, primary source verification of ECFMG is accepted for international medical school graduation.

3) If education cannot be verified because the school has been closed, because the school is in a foreign country and no response can be obtained, or for other reasons, all efforts to verify the applicant's education and training are documented. A good faith effort to verify international education/training is defined as sending at least two verification letters a month apart without receiving a reply at the end of the second month. Documentation of the good faith effort is included in the practitioner's credentialing file.

4) An education institution may designate an organization as its agent for primary source verification for the purposes of credentialing. The verification from this agent is acceptable, i.e., National Student Clearinghouse.

5) For other health care providers, at a minimum, the level of education that is the entry level for the profession or permits licensure must be verified, as well as all advanced education to support approval of the scope of practice, i.e., for an advance practice nurse, qualifying degrees for the registered nurse and the advance practice nurse must be verified.

6) Primary source verification of other advanced educational and clinical practice programs is required if the applicant offers this credential as a primary support for requested specialized privileges.

7) Verification may be obtained from the American Medical Association (AMA) or the American Osteopathic Association (AOA) Physician Database, a profile listing of medical education a physician has received in this country. These data sources contain other information for follow-up, as necessary. The AMA Physician Masterfile is The Joint Commission's designated equivalent for primary source verification for physician education and residency training. *NOTE: The AOA Physician Database is a designated equivalent for: pre-doctoral education accredited by the AOA Bureau of Professional Education, post-doctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic Board certification.* In instances where these profiles do not stipulate primary source verification was obtained, the facility must pursue that verification. Any associated fee is paid by the facility.

c. Verifying Specialty Board Certification

1) Service Line Directors must be certified by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty not appropriate for the assignment, the Clinical Executive Board affirmatively establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the Service Line Director is not board certified, the credentialing and privileging file must contain documentation that the individual has been determined to be equally qualified based on education and experience. Appointment of Service Line Directors without board certification must comply with VHA policy as appropriate.

2) Prior to appointment, the Chief of Staff signs the employment application, VA Form 10-2850, to confirm verification of certification by an American Specialty Board(s), if claimed by a physician applicant or a Dental Specialty Board for dentist applicants. At the request of the Chief of Staff, the Director may delegate responsibility for obtaining information about a candidate's board certification.

3) A physician's board certification is generally verified through VetPro but may be confirmed in the Compendium of Certified Medical Specialists, published by the American Board of Medical Specialists, or the Directory of Medical Specialists, published by Marquis' Who's Who, or direct communication with the officials of the board in question, if necessary. A dentist's board certification may be confirmed by the listings in the American Dental Directory published annually by the American Dental Association or by contacting the appropriate Dental Specialty Board. If listings of specialists are used to verify board certification these must be from current or recently issued copies of the above publications and include copies of the cover page indicating publication date and the page listing the practitioner. Osteopathic specialty certifications from the Advisory Board for Osteopathic Specialists should be confirmed in the Directory of Osteopathic Physicians and A.O.A. Approved Post-Doctoral Training.

4) Board certification and other specialty certificates, which are time-limited or carry an expiration date, must be reviewed and documented prior to expiration.

d. Licensure

1) Applicants must possess at least one full, active, current, unrestricted license to be eligible for appointment. As part of the credentialing process, the status of an applicant's license is primary source verified. (Current licensures are primary source verified at the time of initial appointment, at renewal and/or revision of privileges, and at the time of license expiration.)

2) Verification with state licensing board(s). The Chief of Staff documents

on the employment application, VA Form 10-2850, that the status of all licensures/registrations has been verified with the appropriate state licensing board for all states in which the applicant listed having ever held a license. At the request of the Chief of Staff, the Director may delegate responsibility for contacting state licensing boards.

a) Verification can be obtained through a letter or by telephone and documented on a report of contact. Electronic means of verification also are acceptable, as long as the site is maintained by the primary source and there is no disclaimer regarding authenticity. If verification of licensure is made by telephone or electronic means, a written request for verification must be made within 5 working days and tracked to ensure its receipt within 30 days.

b) If the State is unwilling to provide primary source verification of licensure or other requested information subsequent to written request, the facility must document the State's specifics of the refusal and secure an authenticated copy of the license from the applicant. If the reason for the SLB's refusal is payment of a fee, the facility will pay the fee if the review is for initial appointment.

NOTE: Although credentialing is required for PAs, licensure is not required for employment, so verification of licensure is only required if claimed.

3) Qualification Requirements of Title 38 United Stated Code (U.S.C.) Section 7402 (f). Applicants being credentialed for a position identified in 38 U.S.C. Section 7402(b) (other than a Director) for whom State licensure, registration, or certification is required and who possess or have possessed more than one license (as applicable to the position) are subject to the following provisions:

a) Applicants and individuals appointed on or after November 30, 1999, who have been licensed, registered, or certified in more than one State and who had such license, registration, or certification revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for appointment, unless the revoked or surrendered license, registration, or certification is restored to a full, unrestricted status.

b) Individuals who were appointed before November 30, 1999, who have maintained continuous appointment since that date and who are identified as having been licensed, registered, or certified in more than one State and, on or after November 30, 1999, who have had such revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration. or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for continued employment in such position, unless the revoked or surrendered license, registration, or certification is restored to a full, unrestricted status. Individuals who were appointed prior to November 30, 1999, and have been on continuous appointment since that date are not disqualified for employment by any license, registration, or certification revocations or voluntary surrenders that predate November 30, 1999, provided they possess one full and unrestricted license as applicable to the position.

c) Where a license, registration, or certification has been surrendered, confirmation must be obtained from the primary source that the individual was notified in writing of the potential for termination for professional misconduct, professional

incompetence, or substandard care. If the entity verifies written notification was provided, the individual is not eligible for employment unless the surrendered credential is fully restored.

d) Where the State licensing, registration, or certifying entity fully restores the revoked or surrendered credential, the eligibility of the provider for employment is restored. These individuals would be subject to the same employment process that applies to all individuals in the same job category. In addition to the credentialing requirements for the position, there must be documentation there was a complete review of the facts and circumstances concerning the action taken against the State license, registration, or certification and the impact of the action on the professional conduct of the applicant.

e) This policy applies to licensure, registration, or certification required, as applicable, for the position subsequent to the publication of this policy and required by statute or VA qualification standards, effective with the date the credential is required.

f) When a practitioner enters into an agreement (disciplinary or non-disciplinary) with a State licensing board to not practice the occupation in a State, the practitioner is required to notify VA of the agreement. Information concerning the circumstances surrounding the agreement must be obtained. This includes information from the primary source of the specific written notification provided to the practitioner, including, but not limited to: notice of the potential for termination of licensure for professional misconduct, professional incompetence, or substandard care. If the entity verifies written notification was provided, all associated documentation must be obtained and incorporated into the credentialing and privileging file and VetPro. The practitioner must be afforded an opportunity to explain, in writing, the circumstances leading to the agreement. Facility officials must evaluate the primary source information and the individual's explanation of the specific circumstances, documenting this review in the credentialing and privileging file and VetPro.

g) There may be instances in which actions have been taken against an applicant's license for a clinically-diagnosed illness. Those applicants are eligible for appointment when they are acknowledged by the licensing, registering, or certifying entity as stable, the licensure action did not involve substandard care, professional misconduct, or professional incompetence, and the license, certificate, or registration is fully restored.

4) Exceptions to Licensure. As part of the credentialing process, the status of an applicant's license and that of any required or claimed certifications must be reviewed and primary source verified. Except as provided in VA Handbook 5005, Part II, Chapter 3, subparagraph 14b, all LIPs must have a full, active, current, and unrestricted license to practice in any State, Territory, or Commonwealth of the United States, or in the District of Columbia. The only exceptions provided in VA Handbook 5005 are:

a) An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a State license which is limited on the basis of non-citizenship or not meeting the residence requirements of the State.

b) An individual who has been granted an institutional license by the State which permits faculty appointment and full, unrestricted clinical practice at a specified educational institution and its affiliates, including the VA health care facility; or, an institutional license which permits full, unrestricted clinical practice at the VA health care facility. This exception is only used to appoint an individual who is a well-qualified, recognized expert in the individual's field, such as a visiting scholar, clinician, and/or research scientist, and only under

authority of 38 U.S.C. 7405. It may not be used to appoint an individual whose institutional license is based on action taken by an SLB.

c) An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a time-limited or temporary State license or permit pending a meeting of the SLB to give final approval to the candidate's request for licensure. The license must be active, current, and permit a full, unrestricted practice. Appointments of health care professionals with such licenses must be made under the authority of 38 U.S.C. 7405 and are time-limited, not to exceed the expiration date of licensure.

d) A resident who holds a license which geographically limits the area in which practice is permitted or which limits a resident to practice only in specific health care facilities, but which authorizes the individual to independently exercise all the professional and therapeutic prerogatives of the occupation. In some States, such a license may be issued to residents in order to permit them to engage in outside professional employment during the period of residency training. The exception does not permit the employment of a resident who holds a license which is issued solely to allow the individual to participate in residency training.

5) SLBs may restrict the license of a practitioner for a variety of reasons. Among other restrictions, an SLB may suspend the licensee's ability to independently prescribe controlled substances or other drugs; selectively limit one's authority to prescribe a particular type or schedule of drugs; or accept one's offer or voluntary agreement to limit the authority to prescribe, or provide an "inactive" category of licensure. *NOTE: In such cases, the license must be considered restricted for VA purposes, regardless of the official SLB status.*

6) Some states authorize a grace period after the licensure and/or registration expiration date, during which an individual is considered to be fully licensed and/or registered whether or not the individual has applied for renewal on a timely basis. Facility officials will not initiate separation procedures for failure to maintain licensure or registration on a practitioner whose only license and/or registration has expired if the State has such a grace period and considers the practitioner to be fully and currently licensed and/or registered.

7) Physician applicants including physician residents who function outside the scope of their training program, i.e., who are appointed as a Medical Officer of the Day, must be screened with the FSMB prior to appointment.

a) The FSMB is a disciplinary information service and reports only those disciplinary actions resulting from formal actions taken by reporting medical licensing and disciplinary boards or similar official sources.

b) Screening applicants with the FSMB does not abrogate the medical facility's responsibility for verifying current and previously held medical licenses with the SLB(s).

c) Appointment to the medical staff and granting of clinical privileges is not complete until screening against the FSMB is documented in VetPro. Information obtained through the query must be primary source verified and there must be documentation that this information was considered during the appointment process.

d) Those practitioners who were screened against the FSMB Disciplinary Files by VA Central Office in 2002, or subsequently screened through VetPro, are in VHA's FSMB Disciplinary Alerts Service. Practitioners entered into the VHA's FSMB Disciplinary Alerts Service are continuously monitored. Orders reported to the FSMB from licensing entities, as

well as the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) and the Department of Defense (DOD) initiate an electronic alert that an action has been reported to VHA's Credentialing and Privileging Program Director.

1. The registration of practitioners into this system is based on these queries and only on these queries.

2. This monitoring is on-going for registered practitioners.

3. Alerts received by VHA's Credentialing and Privileging Program Director are forwarded to the appropriate VA facility for primary source verification and appropriate action. The disciplinary information that pertains to the practitioner can then be downloaded and forwarded to the appropriate facility for review and inclusion in the practitioner's credentials file.

4. Facility credentialing staff must obtain primary source information from the State licensing board for all actions related to the disciplinary alert. Complete documentation of this action, including the practitioner's statement, is to be scanned into VetPro before filing in the paper credentials file. Medical staff leadership is to review all documentation to determine the impact on the practitioner's continued ability to practice within the scope of privileges granted.

8) Appointment of Candidates with Previous or Current Adverse Action Involving Licensure. Physicians and dentists, or other licensed practitioners who have had a license or licenses restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, may be appointed under the appointment procedures that apply to other physicians, dentists, or other health professionals.

a) Officials included in the appointment process are to thoroughly review and document the review of all SLB documentation (findings of fact detailing the basis for the action against the applicant's license, stipulation agreements, consent orders, and final orders), as well as the applicant's subsequent professional conduct and behavior before determining whether the applicant can successfully serve as a physician, dentist, or other health care practitioner.

b) To be eligible for appointment, an applicant or employee must meet current legal requirements for licensure (see 38 U.S.C. §§ 7402(b) and (f).

c) If action was taken against the applicant's sole license, or against all the applicant's licenses, a review by the Manager, Human Resources, or Regional Counsel, is necessary to determine whether the applicant meets VA's licensure requirements. Documentation of this review must include the reason for the review, the rationale for conclusions reached, and the recommended action.

d) Those health care professionals who have a current, full and unrestricted license in one or more States, but who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review. The credentials file must be reviewed with Regional Counsel to determine if the practitioner meets appointment requirements. Documentation of this review must include the reasons for the review, the rationale for the conclusions reached, and the recommended action. The review and the rationale for the conclusions must be forwarded to the VISN Chief Medical Officer for concurrence and approval of the appointment.

e. Drug Enforcement Administration (DEA) and Bureau of Narcotic and Dangerous Drug (BNDD) Certification:

1) Physicians, dentists, and certain other practitioners may apply for and be granted renewable certification by the DEA and/or state (BNDD) to prescribe controlled substances. Certification by DEA is not required for VA employment; employees may use the facility's institutional DEA certificate with a suffix.

2) Each applicant is required to provide information on his/her current or most recent DEA and BNDD certificates. Any applicant whose DEA or BNDD certification has ever been revoked, suspended, limited, restricted in any way, or voluntarily or involuntarily relinquished, or not renewed, is required to furnish written explanation at the time of filing the employment application and at the time of reappraisal. Certification must be verified for individuals who claim on the application form to currently hold or to have previously held DEA certification.

3) A state licensing board may obtain a voluntary agreement from an individual not to apply for renewal of certification or may decide to disapprove the individual's application for renewal as part of a disciplinary action taken in connection with the individual's professional practice. While there are a number of reasons a license may be restricted which are unrelated to DEA certification, an individual's state license is considered restricted or impaired for purposes of VA employment if the state licensing board has:

a) Suspended the person's authority to prescribe controlled substances or other drugs;

b) Selectively limited the individual's authority to prescribe a particular type or schedule of drugs; or

c) Accepted an individual's offer for voluntary agreement to limit authority to prescribe.

f. Employment Histories and Pre-employment References:

1) Clinical competence is verified by statements from individuals who are personally knowledgeable of the applicant's professional behavior and clinical performance. At a minimum, documented contact is made with three authoritative references obtained from the applicant, including one from the current or most recent employer or institution where the applicant practiced. Peer recommendations include evaluation of current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

2) Information is requested relative to the scope and level of professional and clinical competence, health status, and fulfillment of responsibility as a member of the Medical Staff. Additionally, findings from the facility's quality improvement program including, but not limited to number of procedures/surgeries performed, number and types of patients treated, mortality rates and infection rates are requested.

3) Supplemental information may be required to evaluate the educational background and/or prior professional experiences of an applicant. The Joint Commission indicates preference for peers to provide reference letters or complete reference forms.

However, in unusual circumstances, these reference checks may be obtained orally and documented in writing. The documentation should include a statement as to why information was secured orally.

4) For an applicant with prior Department of Veterans Affairs (VA) or other Federal service, the Official Personnel Folder should be obtained before the individual is appointed. If an applicant has prior VA service, an effort is made to obtain a reference from officials at the facility where the applicant was previously employed.

g. Health Status

1) Each applicant is required to certify a declaration of appropriate health status. His/her health status must be consistent with a physical and mental capability to perform the duties of their assignment satisfactorily.

2) Determination of the applicant's health status includes a self-declaration of appropriate health status by the applicant. This declaration of health is confirmed by a physician designated by or acceptable to the hospital. Confirmation, at a minimum, is in the form of a countersignature by the confirming physician.

3) All references are solicited as to their knowledge of the applicant's physical and mental capability to fulfill the requirements of his/her assignment.

h. Malpractice Considerations:

1) VA application forms require applicants to give details of any involvement in administrative, professional or judicial proceedings (including Federal tort claims proceedings), in which professional malpractice on their part is or was alleged. If an applicant has been involved in such proceedings, a full evaluation of the circumstances (through primary source verification) is made by officials participating in the credentialing, selection, and approval processes prior to making any recommendation or decision on the applicant's suitability for VA employment. The credentials file will contain an explanatory statement by the practitioner and evidence that the facts regarding resolution of the case(s), as well as a statement of adjudication by an insurance company, court of jurisdiction, or statement of claim status from the attorney, were evaluated. A good faith effort to obtain the documentation is documented by a copy of the refusal letter or a report of contact.

2) The evaluating officials consider the VA's obligation as a health care provider to exercise reasonable care in determining that applicants are properly qualified, recognizing that many allegations of malpractice are proven groundless. Reasonable efforts are made to ensure that only individuals who are well qualified to provide patient care are permitted to do so. NPDB-HIPDB is queried to obtain information regarding malpractice payments made on behalf of the practitioner.

i. National Practitioner Data Bank (NPDB) – Health Integrity and Protection Data Bank (HIPDB):

1) Proper screening through the NPDB-HIPDB is required for applicants, including: physician residents who function outside of the scope of their training program, i.e., appointed as a Medical Officer of the Day; all members of the medical staff and other health care professionals who hold clinical privileges, who are, or have ever been, licensed to practice their profession or occupation in any job title represented in the NPDB and HIPDB Guidebooks; or who are required to be credentialed in accordance with this policy. The NPDB-HIPDB is a

secondary flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB-HIPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, Federal health care program exclusion status, and record of clinical privileges. The information received in response to an NPDB-HIPDB query is to be considered with other relevant data in evaluating a practitioner's credentials; it is intended to augment, not replace, traditional forms of credentials review. NPDB-HIPDB screening is required prior to appointment, including reappointment and transfer from another VA facility, whether or not VA requires licensure for appointment, reappointment, or transfer. This screening must be accomplished within 30 days by enrolling the practitioner in the NPDB-HIPDB PDS. The NPDB-HIPDB PDS provides on-going monitoring of health care practitioners. Facilities are required to renew the enrollment for each practitioner in the NPDB-HIPDB PDS on or before the expiration of the annual enrollment;

2) These procedures apply to all the VHA physicians, dentists, and other health care practitioners who are appointed to the medical staff or who hold clinical privileges whether utilized on a full-time, part-time, intermittent, consultant, attending, WOC, on-station fee-basis, on-station scarce medical specialty contract, or on-station sharing agreement basis.

3) The NPDB-HIPDB is a secondary information source; reported information must be validated with the primary source, i.e., SLB, health care entity, malpractice payer to include, but not limited to the circumstances for payment (e.g., payment history in and of itself is not sufficient).

4) Screening applicants and appointees with the NPDB-HIPDB and enrollment in the NPDB-HIPDB PDS does not abrogate the Chief of Staff's and appropriate Service Line Director's responsibility to verify information prior to appointment, privileging and/or re-privileging, or proposed Human Resources action.

5) If the NPDB-HIPDB screen shows adverse action or malpractice reports, an evaluation of the circumstances and documentation thereof, is required.

6) The facility Director is the authorized representative who authorizes all submissions to the NPDB-HIPDB. Any delegation of that authority to other facility officials is to be documented, in writing, to include date of delegation, circumstances governing delegation, and title (not name) of the official who may make requests.

j. Appointment and Termination of Employment under Title 5 and Title 38 Staff Relative to NPDB-HIPDB Screening

1) Clinically privileged and otherwise credentialed practitioners are to be appointed only after enrollment in the NPDB-HIPDB PDS has been initiated.

2) If the NPDB-HIPDB screen through enrollment in the NPDB-HIPDB PDS shows action against clinical privileges, adverse action regarding professional society membership, medical malpractice payment for the benefit of the practitioner, or Federal health care program exclusion, facility officials must verify that the practitioner fully disclosed all related information required and requested by VA in its pre-employment, credentialing, and/or clinical privileging procedures.

3) The practitioner may be employed or continue in employment only after applicable procedural requirements are met.

4) Any notification from the NPDB-HIPDB PDS must be reported to the Director, Credentialing and Privileging, or designee, within two workdays of receipt of the report.

5) Reviews conducted subsequent to NPDB-HIPDB reports are to be thoroughly documented and include the Service Line Directors as well as the preliminary review by the Clinical Executive Board and could result in a decision to recommend:

a) Appointment, or continue in an appointed status with no change in originally anticipated action.

b) Appointment, or continue appointment status with changes including, but not limited to, modification of clinical privileges or provision of training.

c) Non-appointment or termination.

6) In order to ensure an appropriate review is completed in the credentialing process, a higher-level review must be performed by the VISN CMO to ensure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and confirm that the appointment is still appropriate. The VISN CMO review must be completed prior to presentation to the Clinical Executive Board for review and recommendation to continue the appointment and privileging process.

a) Circumstances requiring review by the VISN CMO are:

1 Three or more medical malpractice payments in payment history,

2 A single medical malpractice payment of $550,000 or more, or

3 Two medical malpractice payments totaling $1,000,000 or more

7) The VISN CMO, in this oversight role, may request additional information as to the specific circumstance of the report or the facility's review process. Files previously reviewed with no change in information do not need to be submitted for VISN CMO review. If there is any change in information at the time of reappraisal, including those files which meet the preceding criteria but were not previously reviewed by the VISN CMO on or before October 10, 2007, it must be referred to the VISN CMO for review.

8) Once requirements for consideration and evaluation of any action reported by NPDB-HIPDB have been completed, the appointment or continued appointment decision, if appropriate, must be made following VHA guidance; Title 5 policies and procedures specified in Title 5 Code of Federal Regulations (CFR) 315, 731, or 752; Federal or VA acquisition regulations; VA Directive and Handbook 0710; and VA Directive and Handbook 5021, as they apply to the category of practitioner.

9) When any initial or subsequent NPDB-HIPDB report calls into question the professional competence or conduct of an individual appointed by VA, the facts and circumstances are to be reviewed to determine what action would be appropriate. Such actions must be closely coordinated with the Human Resources (and in the case of contracts and

sharing agreements with Acquisition and Materiel Management Service) to ensure that they are processed in accordance with applicable requirements.

10) The Director, Credentialing and Privileging, or designee, monitors the fact that a report was received by the facility until the review of the circumstances and any necessary action by facility staff is documented in VetPro. Facility staff must provide updates every 30 days until all information is collected and any necessary action documented; however, closure is expected within 90 days of receipt of the report.

Section 4. Process and Terms of Appointment

a. The service line director to whom the applicant is to be assigned is responsible for recommending appointment to the Medical Staff. The recommendation is based on evaluation of the applicant's credentials and determination that service line criteria for clinical privileges are met.

b. The Professional Standards Board evaluates the credentials of Medical Staff applicants. The Clinical Executive Board recommends Medical Staff appointment based on a determination that Medical Staff criteria for clinical privileges are met.

c. The Hospital Director acts upon appointments to the Medical Staff within 45 days of receipt of a fully complete application including all required verifications, references, and recommendations from the appropriate service line director, Professional Standards Board and Clinical Executive Board.

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

e. Human Resources Management Service verifies the identity of each applicant when the practitioner reports to the hospital to be photographed for the required hospital identification badge. This is done by viewing a current picture hospital ID or a valid picture ID issued by a State or Federal agency, i.e., driver's license or passport.

f. Temporary Appointment for Urgent Patient Care Needs. When there is an emergent or urgent patient care need, a temporary appointment may be approved by the Hospital Director upon recommendation of the Chief of Staff. Prior to making such an appointment, verification of current licensure, confirmation of possession of comparable clinical privileges and a reference will be obtained. Additionally, for physicians, **a response from** NPDB**-**HIPDB PDS registration with no match and a response from FSMB with no report is required. There will be documentation of the specific patient care situation that warranted such an appointment. Temporary appointments are for urgent patient care only and are not used for administrative convenience.

ARTICLE V. CLINICAL PRIVILEGES

Section 1. General Provisions

a. Privileges are facility and setting specific, i.e., privileges are granted within the scope of the facility's mission and approved for the settings in which they can be performed. Only privileges for procedures or clinical services actually provided by the facility are granted to a Medical Staff member. One standard of care is provided regardless of practitioner, service, or location within the facility. Clinical privileges are modified based on the specific location or

setting of care. Our facility has three settings of care: the Hospital, Community Living Center (our long-term care unit) and CBOCs (our community clinics). Hospital privileges requested and granted for each member are posted on our facility webpage. Each CBOC has a separate set of privileges, and these also are posted on our facility webpage for each community clinic location, and only those services can be provided for which privileges have been granted. Any Hospital privileges which also may be performed on Community Living Center are identified on the privilege list and also posted on the hospital webpage.

b. Clinical privileging is the process by which a Medical Staff member is granted permission by the institution to independently provide medical or other patient care services within the scope of his/her license and clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.

c. Clinical privileges are granted for a period not to exceed two years. Clinical privileges are not extended beyond the two-year period, which begins from the date the privileges are signed, dated, and approved by the facility Director.

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

e. Medical Staff members are assigned to and have clinical privileges in one clinical department/service line, but may be granted clinical privileges in other clinical departments/ service lines.

f. Exercise of clinical privileges within any service line is subject to the rules of that service line and to the authority of that service line director or service chief.

Section 2. Process and Requirements for Requesting Clinical Privileges

a. Burden of Proof. The applicant requesting clinical privileges must furnish all information needed for a proper evaluation of professional competence, conduct, ethics and other qualifications. The information must be complete and verifiable. He/she is responsible for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within a reasonable amount of time may serve as a basis for denying clinical privileges.

b. Initial Privileges:

1) Initial clinical privilege requests are initiated by the applicant. The initial application for appointment must be accompanied by a separate request for the specific clinical privileges being requested. The applicant has the responsibility to establish possession of the appropriate qualifications and the clinical competency to justify the request.

2) The applicant's request, as well as verification of the credentials offered to support the request, is provided for review to the appropriate service line director. The service line director reviews all credentialing information including health status (as it related to the ability to perform the requested privileges), experience, training, clinical competence, judgment, clinical and technical skills, professional references, conclusions from performance improvement activities, and any other appropriate information. The service line director recommends approval, disapproval, or modification of the requested clinical privileges. This includes review and confirmation that the space, equipment, staffing and other resources are in place to support the requested privileges. This recommendation may include a limited period of

direct supervision, or proctoring by an appropriately privileged Medical Staff member, for privileges that are high risk.

3) The Medical Director, Geriatrics and Extended Care endorses privileges granted to Medical Staff members to assure that they are competent to manage long-term care patients.

4) The request for privileges, with the appointment recommendation of the Professional Standards Board, is submitted to the Clinical Executive Board for review of the applicant's credentials to determine if clinical competence is adequately demonstrated to support granting the requested privileges. The minutes of the meeting reflect the documents reviewed and the Board's recommendation. The Board's recommendation is submitted to the facility Director. The Hospital Director acts upon clinical privileges within 45 days of receipt of a fully complete application for clinical privileges.

5) Residents who are appointed as Medical Officers of the Day are licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the same requirements as other Medical Staff members.

6) Originals of approved clinical privileges documents are placed in the individual practitioner's credentialing and privileging Folder and a copy is provided to the practitioner. The hospital’s web page has a "Privileges" link that staff can review to ensure physicians are practicing within the scope of their privileges. Hospital staff, with Internet access, have read-only access to the privilege listing for each specialty and to an Active Medical Staff Listing. The Credentials Coordinator updates the Medical Staff List and the appropriate specialty list(s) when initial privileges are granted. Privileges requested at the time of renewal are compared to previously requested privileges and changes are made to the specialty list(s), as needed. The listings also are updated when modification of privileges is granted.

7) The requesting and granting of clinical privileges for the Chief of Staff follows the procedures outlined for other practitioners. The request for privileges is reviewed, and a recommendation made, by the service line director responsible for the specialty area(s) in which the privileges are requested. When considering clinical privileges for the Chief of Staff a member of the Clinical Executive Board chairs the committee and the Chief of Staff is recused from the deliberations. The Clinical Executive Board's recommendation is submitted to the Director for action.

8) A denial of initial privileges, for whatever reason, is not reportable to the NPDB. Where it is determined, for whatever reason, that the initial application and request for clinical privileges should be denied, the credentialing file and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted, and the applicant is informed of the reason for denial.

c. Credentialing for Teleconsultation and Telemedicine. When the staff of the facility determine that telemedicine and/or teleconsultation is in the best interests of quality patient care, appropriate credentialing and privileging is required.

1) The Director is responsible for ensuring appropriate mechanisms are in place to credential and privilege off-site providers who deliver services using telemedicine or teleconsultation both at the site providing telemedicine or teleconsultation and the site receiving these services to insure the care delivered fits within the resources of the facility and scopes of practice of the practitioners.

2) Practitioners treating patients using telemedicine and teleconsultation must be qualified to deliver the required level of consultation, care, and treatment with the appropriate credentialing and privileging, regardless of the technology used, and they must be credentialed and privileged to deliver that care.

3) Teleconsultation. The practitioner providing only teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located when providing teleconsultation services.

a) These practitioner's credentials must be shared with the facility receiving the teleconsultation services.

b) With the exception of the separate NPDB-HIPDB PDS query, the practitioner providing teleconsultation services does not have to be separately appointed or credentialed at the facility or site where the patient is physically located.

c) When the practitioner provides only teleconsultation by offering advice that supports care provided by the on-site licensed independent privileged provider, a copy of the practitioner's current clinical privileges must be made available to the facility or site where the patient is physically located. The practitioner providing teleconsultation services does not have to be separately privileged at the facility or site where the patient is physically located.

4) Telemedicine. When telemedicine services are being provided by the practitioner who directs, diagnoses, or otherwise provides clinical treatment (i.e., teleradiology, teledermatology, etc.) to a patient using a telemedicine link, the practitioner must be appointed, credentialed, and privileged at the facility which receives the telemedicine services (patient site), as well as at the site providing the services. A separate delineation and granting of privileges must be made by the facility receiving the telemedicine services. Appropriate credentialing needs to be performed by the facility receiving the telemedicine services prior to the granting of these privileges.

d. Focused Professional Practice Evaluation (FPPE):

1) FPPE ensures that sufficient organization-specific information is available to confirm the current competency of practitioners initially granted privileges.

a) FPPE is performed to confirm an individual practitioner's current competence at the time initial privileges are granted, or if a currently privileged practitioner requests additional privileges.

b) Practitioners requesting membership but not requesting specific privileges are not subject to the provisions of this policy. They do not require FPPE and may not act as proctors.

c) The process to perform FPPE for current practitioners with existing privileges based on trends or patterns of performance identified by Ongoing Professional Practice Evaluation (OPPE) is defined in the hospital's OPPE policy.

2) FPPE is a process that requires monitoring and evaluation of a provider's professional performance to ensure he/she is delivering safe and high quality patient care. In addition to specialty-specific issues, FPPE also will address the six general competencies of practitioner performance as established by the joint initiative of the Accreditation Council for

Graduate Medical Education (ACGME) and the American Board of Medical Specialties that include:

a) Patient Care: provides 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.

b) Medical/Clinical Knowledge: demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and applies knowledge to patient care and the education of others.

c) Practice-Based Learning and Improvement: uses scientific evidence and methods to investigate, evaluate, and improve patient care practices.

d) Interpersonal and Communication Skills: demonstrates interpersonal and communication skills to establish and maintain professional relationships with patients, families, and other members of the health care team.

e) Professionalism: demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding of and sensitivity to diversity, and a responsible attitude toward patients, the medical profession, and society.

f) Systems-Based Practice: demonstrates 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.

e. Reappraisal:

1) Reappraisal is the process of evaluating the Medical Staff member's professional credentials, clinical competence, and health status. The process includes verifying information provided regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; voluntary or involuntary limitation, reduction or loss of privileges at another hospital, loss of Medical Staff membership, pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment; mental and physical status; and any other reasonable indicators of continuing qualification. Verification of current licensure and changes in licensure and/or registration status is secured. (Primary source verification of licensure is required at initial appointment; at the time of expiration of the license; at the time of reappraisal; and any time modification of privileges is requested.) Verification of NPDB-HIPDB PDS query results, peer recommendations, continuing medical education and continuing education units; and verification of the status of appointments/privileges held at other institutions is secured for review.

2) Evaluation of professional performance, judgment, and clinical and/or technical competence and skills is to be based in part on results of provider-specific performance improvement activities. Ongoing reviews conducted by service line directors will include, when it is not generated as part of a 38 U.S.C. 5705 protected activity, information from surgical case review, infection control review, drug usage evaluation, medical record review, blood usage review, pharmacy and therapeutic review, and monitoring and evaluation of quality, utilization, and appropriateness of care. The process includes consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in clinical practice.

f. Reprivileging:

1) Reprivileging is the process of renewing privileges for a Medical Staff member who currently holds privileges within the facility. This process must be conducted at least every 2 years. Requests for renewal of privileges must be processed in the same manner as initial privileges.

2) The service line director assesses a minimum of two peer recommendations and other information that addresses professional performance, professional judgment, clinical and/or technical skills, disciplinary actions, challenges to licensure, loss of Medical Staff membership, health status, and involvement in malpractice actions.

3) Because facility mission and clinical techniques change over time, it is normal that clinical privileges also may change. The service line director reviews the specific procedures and/or treatments requested. Issues such as documented changes in the facility mission, failure to perform operations and/or procedures in sufficient number or frequency to maintain clinical competence**,** or failure to use privileges previously granted affect the service line director's recommendation for granting privileges. These privileging actions are considered changes and are not considered a reduction, restriction, loss, or revocation of privileges.

4) Approval: The requested privileges and the service line director's recommendation are presented with the supporting credentialing, health status and clinical competence information to the Clinical Executive Board for review and recommendation. The Clinical Executive Board's recommendation is submitted to the facility Director, as the approving authority, for final action.

g. Modification of Privileges:

1) A request for modification of clinical privileges may be submitted at any time. Requests must include documentation that supports the request, i.e., completion of advanced education/clinical practice programs or possession of comparable privileges at other institutions. Primary source verification of all active licenses and completion of advanced training and/or possession of comparable privileges at another facility and a verification of current NPDB-HIPDB PDS enrollment is completed.

2) The request for modification and supporting documentation are provided to the appropriate service line director for him/her to review and make a recommendation to the Clinical Executive Board. The Clinical Executive Board then presents a recommendation to the Director for action.

Section 3. Expedited Appointment to the Medical Staff::

a. Only complete applications, including the verifications and queries required by VHA, are eligible for expedited approval. Application for privileges is ineligible for the expedited process if the CEB makes a final recommendation that is adverse or has limitations. Applications with any current or previously successful challenges to licensure; any history of involuntary termination of medical staff membership at another organization; any involuntary limitation, reduction, denial, or loss of clinical privileges; or an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

b. When a patient care need arises between the meetings of the Professional Standards Board and the Clinical Executive Board, the Hospital Director delegates the authority to render expedited decisions to at least two voting members of the Professional Standards Board.

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

Section 4. Exceptions

a. Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of a temporary appointment by the Hospital Director, or the Acting Director in the absence of the Director. Temporary privileges may be granted while awaiting review and approval by the Clinical Executive Board upon verification of the following: a complete application, no current or previously successful challenge to licensure or registration, no involuntary termination of medical staff membership at another organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. Temporary privileges will be based, at a minimum, on documented evidence of a current state license, comparable clinical privileges, a peer reference, NPDB**-**HIPDB PDS enrollment and other reasonable, reliable information concerning training and current competence. The recommendation for temporary privileges is made by the Chief of Staff and approved by the facility Director, or by the Acting Director in the absence of the Director. Temporary privileges will not exceed 60 calendar days.

b. Emergency care may be provided by any Medical Staff member within the scope of his/her license to save a patient's life or save the patient from serious harm. Properly supervised members of the House Staff may also provide emergency care.

Section 5. Disaster Privileges:

a. In circumstances of disaster(s) in which the emergency management plan has been activated and the facility is unable to manage the immediate patient needs, the Hospital Director and the Chief of Staff or their designee(s) may grant disaster privileges.

b. In order for a volunteer to be considered eligible to act as an LIP, at a minimum a valid government-issued photo identification issued by a State or Federal agency (e.g., driver's license or passport), evidence of current licensure, and one of the following is obtained:

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

2) Primary source verification of licensure 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 hospital, whichever comes first. If primary source verification of licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

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

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

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

3) Identification indicating the individual is a member of the Disaster Medical Assistance Team (DMAT), Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized State or Federal organizations or groups.

4) Identification indicating the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such authority having been granted by a Federal, State, or Municipal entity).

5) Identification by current hospital or Medical Staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a LIP during a disaster.

c. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

d. The practitioner is paired with a currently credentialed Medical Staff member and acts only under his/her direct supervision.

e. Disaster privileges may not exceed 10 calendar days or the length of the declared disaster, whichever is shorter. Upon termination of the disaster, the full credentialing process will be accomplished in order to determine if any follow-up is required.

Section 6. Denial and Non-renewal of Privileges.

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

b. For all other actions in which clinical privileges requested by a practitioner are denied or not renewed, the reason for denial must be documented. If the reason for denial or non-renewal is based on, and considered to be related to, professional incompetence, professional misconduct, or substandard care, the action must be documented as such and is reportable to the NPDB after appropriate internal due process procedures for reduction and revocation of privileges, pursuant to Handbook 1100.19, are provided.

ARTICLE VI. IMPAIRED PROFESSIONAL PROGRAM

Section 1. Purpose

a. The Medical Staff has an obligation to protect its patients from harm, including that which might be caused by an impaired provider. This includes detection of potential problems, uniform investigation and referral of the impaired individual to treatment and rehabilitation. Impairments include those caused by physical illness, psychiatric illness, substance dependence, and/or severe interpersonal stress.

b. The Hospital's Employee Assistance Program provides limited counseling and referral services to any employee who has personal problems that affect or have the potential to

adversely affect conduct and/or work performance. The program seeks to prevent deterioration in work performance, attendance, and/or conduct that can be a result of such problems as psychological, emotional, marital, financial, and legal or illegal drug/alcohol abuse.

c. The goal of this program is to direct impaired practitioners to treatment and rehabilitation, and avoid disciplinary consequences. There may, however, be circumstances, i.e., failure to accept assistance, that lead to corrective action involving clinical privileges and appointment status. Disciplinary action or modification of privileges and/or patient care responsibilities may become necessary to ensure patient safety.

Section 2. Responsibilities

a. Practitioners are responsible for remaining aware of any personal or health problem that may affect their ability to care for patients. They also are responsible for notifying their service line director and seeking treatment should such impairments occur.

b. Practitioners who notice possible impairment in a professional colleague are responsible for ensuring that the issue is dealt with by either persuading the colleague to refer himself/herself for assistance or by informing the service line director. This reporting is confidential.

c. Service line directors are responsible for ensuring patient safety by being aware of any possible problems in their staff's patient care. They are responsible for directing the impaired practitioner to treatment and for following their treatment progress.

d. The Employee Assistance Program provides crisis evaluation of affected individuals and facilitates referral to appropriate and confidential treatment programs.

Section 3. Procedures

a. Self-Referral: A practitioner who perceives possible impairment in his/her performance should discuss the issue with the appropriate service line director. The service line director may need to make changes in clinical duties to ensure that patient care is not adversely affected. Possible actions could include a modification of assignment, back-up coverage, temporary medical leave and, in extreme and persistent cases, a reduction in privileges. The practitioner seeks treatment through the Employee Assistance Program or another source of his/her choice.

b. Supervisory Referral: A service line director who notices, or is informed, that a practitioner has a possible impairment discusses this with the practitioner and investigates to determine whether the impairment is, in fact, occurring. If impairment is confirmed, the practitioner is counseled to seek treatment. The practitioner may appeal to the Chief of Staff or use the grievance procedure. The Chief of Staff may request the Hospital Director to order a physical or psychiatric examination to determine fitness for duty. Disciplinary action may be taken if the practitioner chooses not to seek treatment.

c. Education: Annual education will be provided to the Medical Staff regarding this program and identification of members at risk.

ARTICLE VII. Fair Hearing and Appellate Review

Section 1. Denial of Medical Staff Appointment - When review of credentials and recommendations contained in a complete application result in denial of appointment, the

applicant will be notified by the chairperson of the Professional Standards Board in a letter over the signature of the chairperson of the Clinical Executive Board. The notification will briefly state the basis for the action.

Section 2. Self-Governance Actions

a. Whenever the activities or professional conduct of an individual with clinical privileges are considered to deviate from the standards or aims of the Medical Staff or to be disruptive to the operations of the Hospital, corrective action against such individual may be requested. Such action will follow prescribed VHA regulations relevant to disciplinary action, suspension or termination. Not withstanding, it is the right of the service line director or, in the case of a service line director, the Chief of Staff, or in the case of the Chef of Staff, the Hospital Director, at any time to review and, if necessary, to recommend changes in the clinical privileges of any individual. Such action shall be made known to the individual by special notice and shall be supported by references to his/her specific activities or conduct that constitutes the grounds for the requested corrective action.

b. The automatic revocation of clinical privileges will occur whenever the license of a Medical Staff member is revoked. Clinical privileges will be automatically suspended for the same period that the license is suspended. No right to hearing or appeal exists under these conditions.

c. Whenever a DEA number is revoked or suspended, the practitioner immediately and automatically is divested of the right to prescribe medications covered by the number. The right to hearing and appeal does not apply to this condition.

d. Practitioners who choose not to participate in the teaching program of the Hospital are not subject to denial or limitation of privileges for this reason alone.

Section 3. Actions Against Clinical Privileges:

a. Reduction and Revocation of Privileges:

1) General Provisions

a) This section defines policies and procedures related to the reduction and/or revocation of clinical privileges based on deficiencies in professional performance. Data gathered in conjunction with the hospital's quality improvement program is an important tool in identifying potential deficiencies. However, material which is obtained as part of a protected quality improvement program, i.e., under 38 (United States Code) U.S.C. 3305, 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 quality improvement data. If such information is necessary to support a change in privileges; it must be developed through mechanisms independent of the quality improvement program such as administrative reviews and boards of investigation. In these instances, the quality improvement data may have triggered the review; however, quality improvement information is confidential and privileged in accordance with 38 U.S.C. 3305.

b) Reduction of privileges may include, but not be limited to, 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. Revocation of privileges refers to the permanent loss of

clinical privileges.

c) If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the Fair Hearing and Appeal procedures must be followed.

d) Management officials are prohibited from taking or recommending personnel actions (resignation, retirement, reassignment, etc) in return for an agreement not to initiate procedures to reduce or revoke clinical privileges where such action is indicated. In addition, reporting to the NPDB (including submission of copies to SLBs) may not be the subject of negotiation in any settlement agreement, employee action, legal proceedings, or any other negotiated settlement. Such agreements or negotiations are not binding on VA and may form the basis for administrative and/or disciplinary action against the officials entering into such agreement of negotiated settlement.

e) A reduction or revocation of privileges may not be used as a substitute for disciplinary or adverse personnel action. Where a disciplinary or adverse personnel action is warranted, the action against the privileges is to be incorporated into the due process procedures provided for the disciplinary or adverse personnel action.

f) A practitioner who surrenders clinical privileges, resigns, retires, etc., during an investigation relating to possible professional incompetence or improper professional conduct must be reported to the NPDB in accordance with VA regulations 38 CFR Part 46 and VHA Handbook 1100.17. This includes the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct.

NOTE: Due process under these circumstances is limited to a hearing to determine whether the practitioner's surrender of clinical privileges, resignation, retirement, etc. occurred during such an investigation. If the practitioner does not request this limited hearing the practitioner waives the right to further due process for the NPDB report and needs to be reported immediately.

g) The procedures to reduce and revoke clinical privileges identified in this policy are applicable to the Chief of Staff. All responsibilities normally assumed by the Chief of Staff during the clinical privileging reduction or revocation process must be assigned to an appropriate practitioner who serves as acting chair of the Clinical Executive Board. The Chief of Staff may appeal the Director's decision regarding the reduction of privileges to the Network Director just as all practitioners may appeal such a decision.

NOTE: Any situation that results in a practitioner being proctored, where the proctor is assigned to do more than just observe, but rather exercise control or impart knowledge, skill, or attitudes to another practitioner ensuring that patient care is delivered in an appropriate, timely, and effective manner may constitute supervision. If this occurs after initial privileges have been granted, it is considered a restriction on the practitioner's privileges and, as such, is a reduction of privileges and is reportable to the NPDB if proctorship lasts longer than 30 days from the date the privileges are reduced or placed in a proctored status.

NOTE: Actions taken against a practitioner's privileges that are not related to professional competence or professional conduct may not be subject to these provisions. Examples of actions that may be considered as not reportable include, but are not limited to, failure to maintain licensure and failure to meet obligations of medical staff membership.

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

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

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

NOTE: Proceeding to the reduction or revocation process requires appropriate due process. Guidance should be sought from Regional Counsel and Human Resources to ensure due process is afforded. It is only after the due process is completed, a final action taken by the facility Director, and all appeals have been exhausted that the summary suspension and subsequent reduction or revocation of clinical privileges of a physician or dentist is reported to the NPDB.

2) If the practitioner's clinical privileges are pending renewal and due to expire during a summary suspension or due process procedures for reduction or revocation, the clinical privileges must be denied pending outcome of the review and due process procedures. This denial is considered administrative until such time as a final decision is made in the summary suspension or due process procedures. This final decision determines whether an adverse action has occurred and the responsibility for reporting of the action. If the final action results in what would have been a reportable event, it must be reported in accordance with VHA Handbook 1100.17.

d. Independent Contractors and/or Subcontractors

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

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

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

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

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

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

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

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

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

e. Reduction of Privileges

a) Initially, the practitioner receives written notice of the proposed changes in privileges and the reason(s) for the change from the Chief of Staff. The notice indicates that a report will be filed with the NPDB if reduction or revocation of privileges occurs based on the outcome of the proceedings. A copy of the NPDB report is provided to the appropriate state licensing boards in all states in which the practitioner holds a license and in the state the facility is located. The notice also includes a statement of the employee's right to be represented by counsel or representative of the employee's choice throughout the proceedings.

b) The practitioner is allowed to review all evidence not restricted by regulation or statute upon which the proposed changes are based. Following the review, the practitioner may respond in writing to the Chief of Staff's written notice of intent. The response must be submitted within ten 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

ten workdays except in extraordinary circumstances.

c) Information is forwarded to the Director for decision. The Director makes and documents a decision on the basis of the record. If the practitioner disagrees with the Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within five workdays after receipt of decision.

d) The Director appoints a review panel of three impartial professionals within five workdays after receipt of the employee's request to conduct a review and hearing. At least two members of the panel will be members of the same profession. The review panel hearing will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.

e) 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 the notification letter.

f) During such hearing, the practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of choice to cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

f) The panel will complete its review and submit its report within 15 workdays from the date of the hearing. In cases involving reduction of privileges, a determination will be made as to whether disciplinary action should be initiated. The Director, for extraordinary circumstances or cause, may allow additional time. The panel's report, including findings and recommendations, is forwarded to the Director who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

g) The Director issues a written decision within ten workdays of the date of receipt of the panel's report. If the employee's privileges are reduced, the written decision indicates the reason(s) for the change. The decision and signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.

h) If the practitioner wishes to appeal the decision, he/she may submit a written appeal to the Network Director within five workdays of receipt of the Director's decision. (The appeal option does not delay submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.)

i) The Network Director will provide a written decision based on the record within 20 workdays after receipt of the appeal. The decision of the Network Director is not subject to further appeal.

3) Revocation of Privileges

a) Recommendations to revoke a practitioner's privileges will be made by the Clinical Executive Board and based upon review and deliberation of clinical performance and professional conduct information. A revocation of privileges requires removal from both employment appointment (if applicable) and appointment to the medical staff unless there is a basis to reassign the practitioner to a position not requiring clinical privileges. Such action still may result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct.

b) When revocation of privileges is proposed and combined with a

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

c) In instances where revocation of privileges is proposed for permanent employees under 38 U.S.C. 7401(1), the revocation will be combined with proposed action to discharge the employee under 38 U.S.C., Part V, Chapter 74, Subchapter V. Practitioners whose privileges are revoked for professional incompetence or professional misconduct, are reported to the NPDB. In addition, the practitioner's practice is reviewed for reporting to state licensing boards.

d) For probationary employees appointed under 38 U.S.C. 7401(1), the proposed revocation will be combined with probationary separation procedures contained in MP-5, Part II, Chapter 4. For employees appointed under 38 U.S.C. 7405, the proposed revocation will be combined with actions to separate the employee under the provisions of VA Handbook 5021. Where proposed revocation is based on substandard care, professional misconduct, or professional incompetence, the probationary or temporary employee must be provided with the due process procedures that are provided for reduction of privileges, in addition to the procedures contained in VA Handbook 5021 for separation (i.e., the probationary procedures do not afford sufficient due process). When the proposed revocation is based on other grounds, the proposed revocation must be combined with the applicable separation procedures contained in VA Handbook 5021. Practitioners whose privileges are revoked based on substandard care, professional incompetence, or professional misconduct must be reported to the NPDB according to procedures identified in the VHA policy regarding NPDB reporting.

e) When the revocation of privileges is proposed for employees not covered under the authorities identified in these Bylaws, consideration must be given to discharging or removing the employee, as applicable. It may be desirable to consider other alternatives, such as demotion or reassignment to a position that does not require privileges, where appropriate. Revocation procedures will be conducted in a timely fashion. Appropriate action must be taken to ensure that the employee whose privileges were ultimately revoked does not remain in the same position for which the privileges originally were required.

4) Management Authority. Nothing in these procedures restricts the authority of management to temporarily detail or reassign an employee to non-patient care areas or activities, thus in effect suspending privileges, pending any proposed reduction of privileges or discharge, separation or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges on a temporary basis when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C. 7405 may be terminated when this is determined to be in the best interests of VA in accordance with provisions of MP-5, Part II, Chapter 9 and its VHA Supplement, without regard to the procedural requirements indicated.

Section 4. Reporting Adverse Actions

a. Disclosure of information to State licensing boards regarding practitioners separated from VA service will be completed under the provisions of VHA policy (M-2, part I, chapter 34).

b. Disclosure of information to the National Practitioner Data Bank through State licensing boards regarding adverse action against clinical privileges of more than 30 days will follow provisions of VHA Handbook 1100.17, National Practitioner Data Bank - Reports.

1) VHA facilities must file a report with the NPBD regarding:

a) Any payment for the benefit of a physician, dentist, or other licensed health care practitioner which was made as a result of a settlement or judgment of a claim of medical malpractice subsequent to the review defined in Section 5. Reporting Malpractice Payments.

b) Adverse clinical practice actions, i.e., restriction, suspension, revocation, etc., taken against Medical Staff members that are final and affect privileges for more than 30 days. Acceptance of the surrender of clinical privileges or the restriction of clinical privileges when the action is related to professional competence or professional conduct also is reportable.

2) Malpractice payment reporting applies to all licensed health care professionals. Adverse action reporting applies only to physicians and dentists.

Section 5. Reporting Malpractice Payments

a. Parameters for Reporting Malpractice Payments. Reports to the NPDB for all licensed health care practitioners are in accordance with VHA Handbook 1100.17.

1) Attending staff (including contract employees such as scarce medical specialists) are responsible for the actions of residents and other trainees assigned under their supervision.

a) When the actions of a licensed trainee warrant reporting (for substandard care, professional incompetence, or professional misconduct) but did not result from gross negligence or willful professional misconduct, the supervising attending physician is reported without mention of the involved trainee but with notification that the attending is being reported in a supervisory capacity.

b) In circumstances when the review panel concludes that the payment of a claim was related to substandard care, professional incompetence, or professional misconduct resulting from gross negligence or willful professional misconduct on the part of a licensed practitioner in training or in a residency program, the trainee is reported to the NPDB. In this instance, the attending is not reported unless the review panel concludes there was substandard care, professional incompetence, or professional misconduct on the part of the attending in the supervisory role.

2) Residents who function outside the scope of their training program, i.e., Medical Officers of the Day, are considered and reported, if appropriate, as attending physicians for activities performed in that role.

b. Malpractice Payments Review Process:

1) When a malpractice payment is made, the Regional Counsel notifies the facility and the Director, Office of Medical-Legal Affairs.

2) The facility Director must provide the documents pertinent to the care that led to the claim to the Director, Office of Medical-Legal Affairs. These documents include: medical records of the patient whose care led to the claim, any reports of an administrative investigation appointed to investigate the care, and any other information associated with the care that led to the claim.

3) Upon notification by Regional Counsel that a medical malpractice payment has been made, the Director, Office of Medical-Legal Affairs, appoints professional reviewers. Reviewers may be VA employees or procured by contract, but they may not be employees of the facility for which payment was made.

4) The panel must consist of a minimum of three off-station reviewers who are health care professionals, including at least one reviewer who is a member of the profession or occupation of the practitioner(s) represented in the case and/or claim under review.

5) The reviewers conduct an assessment to determine which practitioners were involved in or responsible for the care of the patient. For each episode, and for each of the involved practitioners, the panel determines whether there was substandard care, professional incompetence, or professional misconduct.

6) The conclusions of the review panel must, at a minimum, be based on review of documents pertinent to the case and/or claim and, to the extent practicable, include information collected directly from the individual(s) for whom payment was made. The panel, at its discretion, may request additional information.

7) The Director, Office of Medical-Legal Affairs, provides a report to the facility Director that documents the conclusion(s) the panel reached regarding substandard care, professional incompetence, or professional misconduct and the rationale for those conclusions(s). Any concerns or questions about the review process must be raised with the Chief Patient Care Services Officer, or designee, who forwards such concerns or questions to the Director, Office of Medical-Legal Affairs. He/she must address the questions or concerns and provide a response to the Chief Patient Care Services Officer, or designee.

8) Reporting to the NPDB and notification to the practitioner follows guidelines identified in VHA Handbook 1100.17.

Section 6. Termination of Appointment

Termination of Medical Staff appointment will be accomplished in conjunction with, and follow procedures for, terminating appointments of practitioners set forth in VHA policy, as appropriate. For practitioners appointed under Title 38, the references include MP-5, part II, chapters 4, 8 and 9, Federal and VA acquisition regulations. For practitioners appointed under Title 5, the references include MP-5, part I, chapters 752, 315, 316 and other relevant authorities.

ARTICLE VIII. ORGANIZATION OF THE MEDICAL STAFF

Section 1. Officers

VA has no requirement for "officers" of the Medical Staff.

Section 2. Leadership

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

b. The Medical Staff, through its committees, service lines and service line directors, provides counsel and assistance to the Chief of Staff and Hospital Director regarding all facets of the patient care services program, including performance improvement, goals and plans, mission and services offered.

c. All Medical Staff members are eligible to be elected for membership on the Clinical Executive Board.

ARTICLE IX. COMMITTEES

Section 1. Clinical Executive Board (Executive Committee of the Medical Staff)

a. Size, Membership

The Chief of Staff is the chairperson of the Clinical Executive Board. Membership consists of the Associate Chiefs of Staff; the service line directors; the Hospital Director or designee (ex officio); the Nurse Executive Associate Director – Patient Services (ex officio); the Medical Director, Geriatrics and Extended Care; the Administrative Assistant to the Chief of Staff as Executive Secretary (ex officio); and one Medical Staff member-at-large. The member-at-large will be elected by and represent the Medical Staff on the Clinical Executive Board, the Affiliation Partnership Council and other boards and committees as necessary for a Medical Staff year. This individual may not hold a centralized position or be a member of the Clinical Executive Board as directed above and may not serve successive terms. Process for election also may be used to remove and replace this individual for cause. Removal will require a two-thirds majority of the voting members of the Medical Staff. Other members include two additional representatives of each clinical service line, Operations Managers of each clinical service line (ex officio), and chairpersons of each reporting committee (ex officio). Only Medical Staff members are voting members of the Clinical Executive Board.

b. Functions

1) Acts for the Medical Staff between Medical Staff meetings.

2) Acts to ensure effective communication between the Medical Staff and the Hospital Director.

3) Makes recommendations directly to the Governing Body (Hospital Director) regarding the:

a) Structure of the Medical Staff;

b) Mechanisms used to review credentials and delineate clinical privileges;

c) Recommendation of individuals for Medical Staff membership;

d) Recommendations for delineated clinical privileges for each eligible individual;

e) Organization of quality improvement activities of the Medical Staff as well as mechanisms used to conduct, evaluate and revise such activities, including patient satisfaction;

f) Proposed mechanisms by which membership on Medical Staff may be terminated;

g) Mechanisms for fair-hearing procedures consistent with approved VA mechanisms or proposed changes to VA approved mechanisms; and

h) Medical Staff ethics and self-governance actions.

4) Receives and acts on reports and recommendations from Medical Staff committees including those with quality of care responsibilities, clinical services and assigned work groups/teams.

5) Assures the performance of required oversight responsibilities as outlined in VHA policy.

6) Requests evaluations of practitioners' privileges through the medical staff process in instances where there is doubt about an applicant's ability to perform the privileges requested.

Section 2. Professional Standards Board

This committee shall consist of members of the Medical Staff selected according to VA regulations to ensure representation of the major clinical specialties and the Medical Staff at large. The committee shall:

a. Review the credentials of all applicants to the Medical Staff and recommend delineation of clinical privileges for such practitioners;

b. Report to the Clinical Executive Board on the qualifications of each Medical Staff applicant;

c. Investigate any reported breach of ethics;

d. Review reports referred by the Clinical Executive Board and Chief of Staff;

e. Evaluate and take action whenever, in the opinion of the appropriate service line director or the Chief of Staff, the continued exercise of clinical privileges by a practitioner would likely lead to serious harm to patients.

f. Review the credentials of PAs and CRNAs and recommend approval of Scopes of Practice.

Section 3. Standing Committees

1. Operative and Other Invasive Procedures/Surgical Case Review

2. Health Information Committee

3. Blood Usage Review

4. Pharmacy and Therapeutics Committee

5. Infection Control Committee

6. Operating Room Committee

7. Critical Care Committee

8. Patient and Family Education

9. Research and Development

10. Peer Review

11. Cardiopulmonary Resuscitation Committee

12. Pain Management Team

Section 4. Committee Records

a. Committees will prepare and maintain reports of conclusions, recommendations, actions taken and results of actions taken. These reports are to be forwarded in a timely manner to the Chief of Staff, committee members, all service line directors or clinical service chiefs and other Hospital personnel, as appropriate.

b. Committees will provide for appropriate and timely feedback to individual service lines for all information regarding those service lines and their providers.

ARTICLE X. CLINICAL SERVICES (SERVICE LINES)

Section 1. Characteristics

a. Medical Staff members are assigned to a service line to carry out services under leadership of a service line director.

b. Convenes regular meetings to receive, review and consider patient care analysis findings, and the results of other review, evaluation and monitoring activities.

Section 2. Functions

a. Provide quality patient care.

b. Provide for continuous quality improvement within the service line, to consider findings of ongoing monitoring and evaluation of quality (including access, efficiency, effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; risk management activities; and utilization management.

c. Assist in identification of important aspects of care for the service line, identification of indicators used to monitor quality and appropriateness of important aspects of care, and evaluation of the quality and appropriateness of care.

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

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

f. Define, develop and maintain a set of delineated general, specialty and procedure-specific clinical privileges pertinent to that clinical service line.

g. Develop policies and procedures to assure effective management, ethics, safety, communication and quality within the service line.

Section 3. Selection and Appointment of Service Line Directors - Service line directors are appointed by the VISN Director based upon the recommendation of the Hospital Director, Affiliation Partnership Council (if appropriate), VA Headquarters Service Director and the appropriate VA Headquarters Professional Standards Board.

Section 4. Duties and Responsibilities of Service Line Directors - Service line directors are responsible and accountable for:

a. All professional and administrative activities within the service line including selection, orientation and continuing education of staff. This includes the integration of the service line/department into the primary functions of the organization; coordination and integration of interdepartmental and intradepartmental services; the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services; the recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services; the determination of the qualifications and competence of service line personnel who are not licensed independent practitioners and who provide patient care, treatment, and services; the maintenance of quality monitoring programs, as appropriate; and recommending space and other resources needed by the service line.

b. Monitor and evaluate the quality of care provided in the service line. This includes access, efficiency, effectiveness and appropriateness of care and treatment of patients served by the service line and the clinical/professional performance of all individuals in the service line. This must include relevant elements such as surgical case review, medication usage evaluation, medical record review, blood usage review, risk management, infection control, and utilization review as reported by committees tasked with these functions and/or direct evaluation of the service line director.

c. Assuring that individuals with clinical privileges competently provide service within the scope of privileges granted.

d. Recommending to the Medical Staff the criteria for clinical privileges in the service line after development and approval of such criteria by the service line members.

e. Recommending to the Medical Staff the settings in which specific privileges can be performed.

f. Recommending appointment and clinical privileges for each member of the service line and others requesting privileges within the service line.

g. Assessing adequacy and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization and providing appropriate feedback, as applicable.

ARTICLE XI. MEDICAL STAFF MEETINGS

1. General Medical Staff Meetings:

a. Medical Staff meetings are held at least twice a year and on an as needed basis at the call of the Chief of Staff. Regular meetings of the Medical Staff are convened at the call of the Chief of Staff. Special meetings may be convened at the call of the Hospital Director, the Chief of Staff, the Clinical Executive Board or not less than one-fourth of the members of the active Medical Staff.

b. The presence of 50 percent plus one of the Category I voting members of the Medical Staff at any regular or special meeting shall constitute a quorum for the transaction of all business.

2. Medical Staff Committee and Service Line Meetings:

a. Committees and service lines may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these Bylaws, VHA policy, Joint Commission standards and Hospital policy memoranda, as appropriate.

b. A quorum for purposes of Medical Staff committee meetings and service line staff meetings is defined as 50 percent plus one of all voting members.

ARTICLE XII. RULES

The Medical Staff shall adopt such rules 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 Hospital Director. Such rules shall be a part of these Bylaws except that they may be amended or repealed at any regular meeting at which a quorum is present with prior notice, or at any special meeting by notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Hospital Director.

ARTICLE XIII. AMENDMENTS

1. The Bylaws and Rules are reviewed at least annually, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Any Medical Staff member may submit proposed amendments to the Bylaws and Rules in writing through the Chief of Staff.

2. Written text of proposed significant changes is provided to Medical Staff members at least ten days prior to consideration of the proposed amendment(s).

3. All changes to the Bylaws require action by both the Medical Staff and Hospital Director. Neither may amend unilaterally. The affirmative vote of a majority of the Medical Staff members eligible to vote, either by written ballot or by action at a meeting of the Medical Staff at which a quorum is present, will serve as adequate action.

4. Changes are effective when approved by the Hospital Director and by the VISN.

ARTICLE XIV. ADOPTION

These Bylaws, together with the appended Rules, shall be adopted upon recommendation of the Medical Staff at any regular or special meeting of the active Medical Staff or Clinical Executive Board at which a quorum is present or through electronic vote. Once adopted, they shall replace any previous Bylaws and Rules and shall become effective when approved by the Hospital Director and the VISN.

Adopted by the Medical Staff of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri on this date, April 26, 1995.

Amended and accepted by the Medical Staff of the Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri on this date, May 8, 2009.

RECOMMENDED:

WILLIAM P. PATTERSON, M.D.
Chief of Staff

APPROVED:

SALLIE HOUSER-HANFELDER, FACHE
Director

APPROVED:

JAMES SANDERS, M.D.
Acting Chief Medical Officer

MEDICAL STAFF RULES

A. INTRODUCTION

1. Medical Staff Rules shall be established concerning the conduct of the Medical Staff. Authority for establishment and amendment of the Rules shall require the action of the Clinical Executive Board or of the Medical Staff prior to final approval by the Hospital Director and the VISN.

2. Rules shall be established which refer to the administrative conduct of Medical Staff work in general as well as to specific areas of medical care or clinical activity. These may be recommended by any service line, service line director or committee of the Medical Staff and shall require approval of the Clinical Executive Board or of the Medical Staff prior to approval by the Hospital Director and the VISN.

3. In addition to the Rules detailed below, other VA regulations and Hospital policy memoranda delineate the policies and procedures of this hospital.

4. All Medical Staff members and other professional staff, as appropriate, shall serve on committees as assigned.

B. GENERAL

1. The Rules relate to the roles and/or responsibilities of members of the Medical Staff and individuals with clinical privileges in the care of inpatients, emergency care patients and ambulatory care patients as a whole or to specific groups as designated.

2. Rules of departments**,** service lines or services will not conflict with each other, with Bylaws, Rules and policies of the Medical Staff or requirements of the Governing Body.

C. PATIENTS' RIGHTS

1. Patients' Rights and Responsibilities: The Medical Staff and Hospital support the rights of each patient and publish hospital policies and procedures to address such rights including:

a. Reasonable response to requests and need for service within capacity, mission, laws and regulations;

b. Considerate, equitable, humane and respectful care and treatment;

c. Collaboration with physicians in matters regarding personal health care and the right to know the identity of the attending physician and House Officer who are primarily responsible for his/her care;

d. Formulation of advance directives including appointment of a surrogate to make health care decisions;

e. Access to information necessary to make health care decisions that reflect the patient's wishes;

f. Access to information about patient rights and handling of patient complaints;

g. Participation of the patient or representative in consideration of ethical decisions regarding care;

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

i. Personal privacy and confidentiality of information;

j. Action by legally authorized person to exercise a patient's rights if the patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or is unable to communicate wishes; and,

k. Foregoing or withdrawing life-sustaining treatment including resuscitation.

2. Advance Directive

A patient's right to execute an advance directive is recognized and supported by the Medical Staff and the Hospital. Pertinent VHA and Hospital policy outlines procedures for the execution of an advance directive.

3. Informed Consent

a. The responsible practitioner (or House Officer working under his/her supervision) must inform a patient or representative, as appropriate, of the name, nature and details of a proposed diagnostic/therapeutic procedure or course of treatment as well as the indications therefore, expected benefits, associated risks, complications or side effects, reasonable and available alternatives and anticipated results if nothing is done. This information must be provided in language understandable to the patient. The patient or representative must have the opportunity to ask questions, to indicate a comprehension of the information provided and to grant permission for performance freely, without fraud, duress, deceit or coercion, and to withhold or to revoke such permission without jeopardizing his/her right to future medical care and treatment.

b. The responsibility for providing the information and for obtaining consent is that of the Practitioner (or House Officer under his supervision) who has primary responsibility for the patient or who will be performing the particular procedure/treatment. This communication process should be documented in an electronic progress note with an appropriate Informed Consent title.

c. The fact that the patient has been provided appropriate information and counseling and that he/she has consented to the proposed procedure/treatment should be documented in the progress notes of the patient's medical record. This note should indicate that the patient (or other individual giving consent) was informed and understands the purpose and nature of the procedure, the possible alternatives, reasonably expected outcome, possible risks of complication and the patient's condition at the time the information was provided and consent was given. In the event of a refusal or a revocation of consent, a progress note should document such and indicate that consequences of such refusal or revocation were discussed with the patient or patient's representative.

d. Informed consent should be obtained and documented for all diagnostic and therapeutic procedures which:

1) Require the use of sedation;

2) Require analgesia or anesthesia;

3) Produce significant discomfort to the subject;

4) Have significant risk of complication or morbidity.

5) Require injections of any substance into a joint space or body cavity.

6) Involve testing for HIV

e. In the case of need for repeated thoracenteses or paracenteses or similar procedures for therapeutic reasons, a written permit with the first procedure is usually sufficient. If there is any doubt about the need for a written consent, it should be obtained.

f. In the event of a life-threatening emergency, it may be necessary to proceed without written consent of the patient. Authority must be granted by the Chief of Staff/designee before proceeding in this situation unless an immediate critical medical problem intervenes.

g. When a patient is under the age of 18 or unable to give consent (legally incompetent, comatose, etc.), signature of a representative or legal guardian must be obtained and similarly witnessed, dated and timed.

h. In the event of an emergency a patient who cannot give consent and the person having the authority to grant the consent is not on the premises, consent may be obtained by telephonic conference call utilizing HAS employee as a third party and having the call recorded. The recording is clearly labeled to include patient's name, identification number, date and identity of the Hospital. The Transcribed report is a legal document and as such is maintained in CPRS. Prior to the recording the guardian or next of kin are given the opportunity to request a copy of the report. If so requested a copy will be forwarded with a letter signed by a physician.

i. If the patient is unable to give consent and the party who has the authority to grant consent is not available or non-existent, authority must be granted by the Chief of Staff/designee before initiating any emergency procedures. In instances where the procedure is not of an emergent nature, it may be necessary to proceed with a court order for guardianship before consent appropriately can be obtained.

j. The execution of informed consent shall be consistent with legal requirements and ethical standards; for example, the potential conflict of interest in research as a researcher and a clinician must be addressed.

k. A properly executed informed consent must be documented in the medical record before procedures or treatment for which it is required may be performed or provided.

D. GENERAL RESPONSIBILITY FOR CARE

1. Conduct of Care

a. Management of a patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff. This responsibility extends to all categories and settings of care provided under the auspices of the Hospital.

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

2. Emergency Services

a. This hospital is designated as a Level III emergency services facility according to Joint Commission definition.

b. These services will be guided by written policies and procedures appropriate to a Level III emergency services department.

c. Physician staffing is consistent with the facility emergency services level designation.

d. Evaluation of applicants regarding emergent need and treatment or referral will be provided.

e. Referral of applicants without emergent/urgent care needs or legal eligibility for care will be handled appropriately.

3. Admissions

a. Individuals with admitting privileges are physician members of the Medical Staff and their House Staff members. The Hospital shall admit for care and treatment legally eligible patients suffering from any type of disease which, in the opinion of the admitting member of the Medical Staff, can be adequately cared for at this Hospital. Also Medical Staff physicians and their House Officers shall admit for care and treatment any person for humanitarian purposes until such time as that person may be safely transferred to another hospital or other suitable facility. The determination of legal eligibility is defined by law and by the Department of Veterans Affairs (VA).

b. Criteria for standards of medical care regarding patient admissions include:

1) Prompt medical evaluation will be provided by a qualified physician. A patient may be admitted to or denied admission to the Hospital only by a Medical Staff physician or House Officer. All practitioners shall be governed by the official admitting policy of the Hospital. A non-physician staff member or Specified Professional Personnel with clinical privileges may, with the concurrence of an appropriate physician, initiate the procedure for the admission of a patient. The actual admission function is the responsibility of a Medical Staff physician or their House Officer. Admission to inpatient care by any member of the Medical Staff who is not a member of a service assigned beds requires the concurrence of the appropriate service line director or designee.

2) There are no exceptions to the above criterion. Each inpatient shall be the responsibility of a member of the Medical Staff. The Hospital shall admit legally eligible patients (as defined by all applicable VA regulations) suffering from any type of disease

or injury. The Medical Staff physicians (or their House Officers) will examine and arrange the proper disposition of all eligible patients. Any patient may be admitted for emergency care.

3) Responsible physicians have been delegated full authority for the admission of patients to the Hospital. When an admission to a specialty service is considered to be necessary by the admitting physician, the service will be contacted for consultation. If this is not provided within one hour, the admitting Medical Staff physician or their House Officer may admit the patient to the service in question after consultation with the respective service line director or bed service chief or his/her designee.

4. History and Physical (H&P) Examination

a. A history and physical examination and initial plan of care shall be entered in to the medical record and authenticated by a Medical Staff physician or their House Officer within 24 hours of the patient admission.

b. Other individuals permitted to perform H&P examinations based on approval of the Medical Staff must have confirmation or endorsement of findings, conclusions and assessment of risk by a qualified physician within 24 hours after admission.

5. Procedures - All patients shall be attended by members of the Medical Staff and shall be assigned to that section of the service line concerned with the treatment of the disease that necessitated admission. The patient shall be under the care of the practitioner assigned to that specific section at the time of admission who is responsible for:

a. Medical care and treatment.

b. Prompt completion and accuracy of the medical record.

c. Special instructions.

d. Transmitting reports on condition of the patient to the referring practitioner and the family of the patient.

e. Except in an emergency, not admitting until after a provisional or admitting diagnosis is entered into the medical record.

6. Tests - Each patient admitted to the Hospital shall have appropriate laboratory and radiologic examinations as required.

7. Transfers

a. The Hospital prohibits the arbitrary transfer of any eligible patient when the Hospital has the means to provide adequate care to that patient. Emergency care for any individual may be provided for humanitarian reasons if the immediate referral to a suitable trauma center is not feasible. When stable, such individuals will be transferred for appropriate care after arrangements have been made with the accepting facility.

b. The Hospital will accept eligible patients in transfer from the private sector when it is determined that the facility has the ability to meet patient needs and consent to accept the stabilized patient is provided by a medical staff member or House Officer.

1) The transferring hospital is medically responsible for the patient during transfer.

2) All pertinent medical information will accompany the patient.

c. Transfers from one service line or service to another within the Hospital will be accomplished only by mutual agreement of the service lines or services involved. The transferring Medical Staff physician or the House Officer responsible for the patient's care shall not transfer patients from one service line or service to another or to or from an ICU without a written order.

d. Transfer priorities are as follows:

1) From Outpatient area to appropriate patient bed.

2) From ICU to general care area.

3) From temporary placement in another geographic or clinical service area to the appropriate area for that patient.

e. Admission to and Discharge from ICU: If any question as to the validity of admission to or discharge from an ICU should arise, that decision is to be made through consultation with the unit director or service line director or chief of service.

f. Interfacility transfer from the Hospital requires completion of appropriate progress note and informed consent documented in IMED.

8. Consultations

a. The good conduct of medical practice includes the prompt and timely use of consultation. Judgment as to the serious nature of the illness and the question of doubt as to diagnoses and treatment rest with the practitioner responsible for the care of the patient. It is the duty of the organized Medical Staff to see that those with clinical privileges do not fail in the matter of obtaining consultation as needed.

b. Any qualified practitioner with clinical privileges in the Hospital can be contacted for consultation within the area of expertise.

c. A consultation shall be completed when the consultant, in his/her medical judgment, has provided the requesting physician with an opinion and recommendation. Such consultation shall be entered into the medical record, reflect examination of the patient, and include impressions and recommendations.

d. Except in an emergency, consultation is recommended in the following situations:

1) When the patient is at questionable risk for operation or treatment;

2) When the diagnosis is obscure after ordinary diagnostic procedures have been completed;

3) When there is uncertainty as to the choice of therapeutic measures to be utilized;

4) In unusually complicated situations where specific skills of other practitioners may be needed;

5) In instances where the patient exhibits psychiatric symptoms or inappropriate emotional responses;

6) When requested by the patient or the family;

7) When an underlying medical condition places a patient at significant risk during an oral surgical or other dental procedure, whether in the operating room or in the dental clinic.

e. The staff practitioner must meet with each patient who received a consultation by a resident and perform a personal evaluation in a timely manner based on patient condition and local policy.

9. Discharge Planning

a. Discharge planning is the process in which the patient and various health care personnel work together to facilitate the transition from one environment to another. It will be initiated on admission and when the need is identified.

b. Discharge planning must take into consideration the unique needs of the patient and provide for continuity of care to meet those needs.

c. A documented discharge plan will be entered in the patient's medical record. Such factors as high-risk screening, involvement of the patient, family and appropriate Hospital staff as well as an assessment of the planning process should be examined.

d. Criteria

1) Availability of appropriate services to meet patient needs;

2) Special concerns such as assistance with transportation, patients in high-risk categories (chronic and/or disabling illnesses or disease), inadequate family or community support systems and catastrophic illnesses.

10. Discharge

a. Criteria for discharge are approved by the Clinical Executive Board as discharge screens for utilization review appropriateness and length of stay purposes. These criteria are reviewed and revised, as necessary, annually.

b. Based upon the medical judgment of the attending Medical Staff physician, exceptions can be made in order to delay discharge of a patient. Such exceptions will be approved based upon documented justification of the attending physician or his/her House Officer.

c. Discharge from the Intensive Care Unit (ICU) will be based on criteria approved by the Clinical Executive Board. These criteria, including priority determinations, are reflected in the Policy and Procedure Manual for ICU.

d. Discharge from a Post Anesthesia Care Unit (PACU) area will be based on the order of a licensed independent practitioner familiar with the patient or, when the practitioner is not available, based on criteria approved by the CEB. The responsible practitioner's name will be recorded in the patient's medical record.

11. Autopsy

a. To improve patient care and professional knowledge, every Medical Staff physician is expected to actively participate in securing autopsies. Except when directed by a public officer or agency authorized by law to order an autopsy, it is unlawful to perform an autopsy without the consent of one of the following in the order listed:

1) The deceased if in writing and duly signed and acknowledged prior to his/her death;

2) The surviving spouse;

3) A surviving child, parent, sibling;

4) Any other relative, by blood or marriage;

5) Close personal friend who assumes such responsibility.

b. The Medical Staff physician or House Officer will provide information regarding clinical diagnosis and concerns to the pathology staff prior to the autopsy, specifically including any infection hazards. Other information such as any limitation imposed by the consenting party also should be provided to the pathology staff by the physician staff.

c. The Medical Staff of this teaching hospital believe and support the idea that autopsies are a valuable component of medical education. Therefore, attempts to secure autopsies are to be carried out for all Hospital deaths. Special emphasis will be placed on deaths which are considered unexpected or unusual.

d. Findings from autopsies will be used as a source of clinical information in quality improvement activities.

E. PHYSICIANS' ORDERS

1. General Requirements

a. All orders for treatment shall be electronically authenticated and shall include the date and time of the order. Specific professional personnel in special care units may have authority to institute specific treatment and/or medications by protocol or policy as previously delegated by the supervising Medical Staff physician.

b. Orders may be instituted only by Medical Staff members, House Staff members and by other individuals within the authority of their clinical privileges or scope of practice.

2. Medication orders

a. All medication orders will include the full name of the drug (generic preferred), dosage, route and frequency of administration or time intervals between doses. A dosage range is not acceptable.

b. It is unacceptable to order "as directed" or "prn" without a frequency of administration. PRN medication orders must include an indication.

c. Self-administration of drugs by patients shall be permitted only if specifically ordered by the responsible physicians and according to established Hospital policy.

3. Standing Orders

Standing orders are acceptable in order to routinize the conduct of certain procedures in a service. The service line director or chief of service formulates these after suitable consultation with members of the service and after appropriate liaison with other service line directors or chiefs of service whose conduct of clinical activities may be affected by the standing order. The Chief of Staff will approve all standing orders.

4. Verbal Orders

a. All orders for treatment shall be entered and authenticated including the date and time by the medical professional except under the following circumstances:

1) In the management of emergency circumstances when the urgency of the clinical situation requires verbal/telephone orders, e.g., during cardiopulmonary resuscitation;

2) When written or electronic orders are not practical, e.g., when the staff member is gloved during a procedure requiring sterility and an order is required;

3) To care for a clinical problem when the responsible physician is out of the Hospital building.

b. Verbal/telephone orders may be accepted and entered by professional registered nurses, physician assistants, registered pharmacists, respiratory therapy personnel, medical technologists and other staff designated by CEB.

c. The staff member who receives the verbal/telephone order is required to write down the complete order or enter it into CPRS, then read it back to be verified by the individual who gave the order. During true emergency situations, such as a Code Blue, or in the operating room, "read-back" may not be feasible and "repeat back" may be used.

d. Verbal/telephone orders must be immediately entered in the patient record and electronically signed by the individual receiving the order. It must be countersigned by the requesting provider within 24 hours or by discharge, whichever occurs first.

5. Investigational Drugs

Investigational drugs will be used only when approved by the appropriate Medical Staff committee. Requests for investigational drugs that are to be used for clinical application on a specific patient only will be submitted to the Pharmacy and Therapeutic Committee for review and approval. Requests for multiple case usage will be reviewed by the Research and Development Committee and approved by the Hospital Director. Such drugs will be

administered only under an approved protocol with patient informed consent and under the direct supervision of the authorized principal investigator or collaborating physician with a non-physician principal investigator.

6. Submission of Surgical Specimens

All tissues and foreign material removed during an operation, including teeth and fragments removed in dental procedures, shall be sent to the Hospital pathologist or designee who shall make such examination as considered necessary to arrive at a pathological diagnosis.

7. Special Treatment Procedures

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

1) The roles of attending physicians, family members and, when applicable, other staff in the decision making process are clearly defined in VHA and Hospital policy.

2) Mechanisms for reaching decisions about withholding or withdrawal of resuscitative services for competent and incompetent patients including mechanisms to resolve conflicts in decision-making are clearly defined in VHA and Hospital policy and will be followed by all involved Hospital staff.

3) Requirements concerning documentation of the decision making process and the requisite orders in the medical record shall be followed by all Medical Staff physicians.

b. Protective Security - For the protection of patients, staff and the Hospital, certain principles are to be met in the care of the potentially combative or emotionally disturbed outpatient or inpatient:

1) When patients are known or suspected to be suicidal or assaultive, they must have prompt attention and Behavioral Health consultation should be considered.

2) Following a Behavioral Health consultation, patients who are at high risk for suicidal or assaultive behavior will be admitted to the Acute Psychiatric Care Unit for appropriate treatment or otherwise managed to protect themselves or others from harm.

3) If a suicidal or assaultive patient requires acute medical or surgical management, the patient may be admitted to a general area of the hospital, but appropriate observation and precautions, including special nursing care, must be provided.

c. Restraint and Seclusion.

1) It is the goal of this facility, to the greatest extent possible, to be restraint free. No PRN or "may restrain" orders are permissible.

2) In the event restraints are necessary, the least restrictive mode will be used. Seclusion will only be ordered in the Behavioral Health care area. All use of restraint protocols requires authorization by physician order. Staff physicians and residents in at least their second post-graduate year are authorized to order restraint use by protocol or order.

3) Clinical justification is required for the use of restraining devices. The classification of a restraint is based on its use. Restraining devises are used when other less restrictive interventions have failed. These less restrictive devices include but are not limited to removal of patient from stimuli/stressors and use of therapeutic interactions/principles or crisis intervention.

d. Emergency Commitment - This Hospital cooperates to the maximum extent possible in providing care to eligible patients who are involuntarily detained or civilly committed. All medical staff members who will participate in the commitment procedure must receive instruction from a Missouri State Mental Health Coordinator and be certified by the Missouri Department of Mental Health. Procedures concerning this activity are outlined in Hospital policy and shall be followed.

e. The Behavioral Health Service Line is responsible for the operation of the mental health treatment programs at this Hospital which provide for the care of patients suffering from acute psychiatric disorders, acute exacerbations of chronic psychiatric disorders and substance abuse. This care and treatment is provided through a multidisciplinary treatment program with the provision of multidisciplinary treatment planning for each patient.

F. ROLE OF ATTENDING PHYSICIAN STAFF

1. Supervision of House Staff and Non-Physicians

a. All House Staff, without exception, will function under the supervision of Medical Staff physicians. A responsible staff practitioner must be immediately available to House Staff members in person or by telephone, and able to be present within a reasonable period of time if needed. Each patient will be assigned to an attending Medical Staff physician who maintains the responsibility for care provided to that patient.

b. Each training program will be structured to encourage and permit House Staff to assume increasing levels of responsibility commensurate with individual progress in experience, skill, knowledge and judgment. VHA and Hospital policies describe the methods of determination and documentation of these graduated levels of responsibility.

c. House Staff may write patient care orders, perform diagnostic/therapeutic procedures and provide all other direct patient care activities under the supervision of the assigned attending physician. The attending physicians are responsible for the care which is provided under their supervision.

d. Medical Staff members who choose not to participate in the teaching programs are not subject to denial or limitation of privileges for this reason alone.

2. Documentation of Supervision

a. When members of the House Staff are involved in patient care, appropriate documentation in the medical record will demonstrate active participation in, and supervision of, the patient's care by the responsible attending physician. Sufficient documentation includes, at a minimum:

1) Progress notes which document that care is directed by the attending physician and that the level of supervision is appropriate based on the nature of the

patient's condition, the likelihood of major changes in the management plan, the complexity of care and the experience and judgment of the House Officer being supervised.

2) For patients admitted to an inpatient service, an attending physician must meet the patient early in the course of care, within 24 hours of admission. That attending physician must personally document, in a progress note no later than the day after admission, findings and concurrence with the resident's initial diagnosis and treatment plan as well as any modifications or additions.

3) Documented participation in attending rounds.

4) Electronic progress notes or cosignature of House Officer's progress notes concerning high-risk or technically complex treatment modalities.

5) Periodic electronic notes, as necessary, when major changes in patient management occur, hospitalization is extended and/or complications are recognized.

6) Cosignature of the Hospital discharge summary.

7) Cosignature of resident documentation.

b. Entries in the medical record made by House Staff or non-physicians (e.g., Physician Assistants, Nurse Practitioners, etc.) that require electronic countersignature by supervisory or attending medical staff members within 72 hours or by date of discharge, whichever is sooner, are as follows:

1) Inpatient medical history and physical examination;

2) Hospital discharge summaries.

G. MEDICAL RECORDS

1. Authentication

All entries in the medical record shall be dated, timed and authenticated. Only authorized individuals will make entries in the patient record. This includes members of the Medical Staff, House Staff, licensed clinical staff and others as specified by policy.

2. Use of Abbreviations

a. The CEB annually will update the Unapproved Abbreviation List, based upon the recommendation of the Medical Staff through the Health Information Committee. This list will be available on the Hospital's webpage. These abbreviations are not to be used for documentation in the patient record.

b. Abbreviations are not permitted in medication orders.

3. Reports of diagnostic and therapeutic procedures should be completed with authentication/verification as soon as possible, preferably within 24 hours after the procedure.

4. Release of Information

a. Requirements for release of information are specifically described in pertinent Hospital policy. Access to medical records of patients shall be afforded to Medical Staff members for approved study and research, consistent with provisions of the Privacy Act of 1974, the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), as well as other pertinent federal laws on protected information.

b. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute or with the written permission of the Health Information Manager, when acting in accordance with established VA regulations.

5. Basic Patient Information Requirements

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

b. Medical history including history and details of present illness/injury.

c. Observations, including results of therapy.

d. Diagnostic and therapeutic orders.

e. Report of procedures, tests and their results.

f. Progress notes.

g. Consultation reports.

h. Conclusions at termination of hospitalization or evaluation/treatment.

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

j. Identification of attending physician by name.

6. Inpatient Medical Records: In addition to basic patient information requirements above, inpatient medical records must include the following:

a. Patient identification number.

b. History that includes relevant past, social, family, military and occupational information completed within 24-hours of admission.

c. A complete physical examination, which includes all pertinent findings resulting from an assessment of all body systems completed within 24 hours of admission. *(Exceptions: If a complete history and physical examination has been recorded within a week prior to admission to the Hospital, these reports may be used in the patient's medical record in lieu of the admission history and physical examination provided that these reports were recorded by a Medical Staff practitioner or supervised House Officer. In such instances, an interval admission note, which includes all additions to the history and any subsequent changes in the physical findings, must be recorded. The interval history and physical note also may be used if the patient is readmitted within 30 days for the same or related problems.)*

d. The medical record shall contain a current and thorough physical examination prior to performance of surgery.

e. A documented discharge plan shall reflect involvement of the patient, family and interdisciplinary staff including physicians, nurses and social workers. Discharge planning is the process of activities that involves the patient and various health care staff working together to facilitate the transition of that patient from one environment to another. It is not limited to placement in long-term care facilities, but shall include referrals to various community agencies and hospital services that may be required to improve or maintain the patient's health status as well as discharges to home.

f. A discharge clinical summary shall be routinely entered or dictated within 24 hours following discharge. Summaries for death cases or for irregular discharges (Against Medical Advice) will be dictated or entered within 24 hours of the patient's release. These will include a pertinent summary of the medical record, condition of the patient at the time of discharge, medications, limitations, diagnosis and recommended follow-up care. Dictation or entry of summaries will be in accordance with VA requirements.

g. When an autopsy has been performed, the anatomic diagnoses will be available within 3 days and the complete protocol will be available within 60 days.

h. The medical record will be completed within 30 days. The record is ordinarily considered complete when the required contents, including any required discharge summary or final progress note, are assembled and authenticated and when all final diagnoses and any complications are recorded.

i. Except on the order of the Chief of Staff, based on the recommendation of the Medical Record Committee, no medical record will be declared complete until it contains all of the required documentation pertinent to patient treatment. Any records declared complete on the order of the Chief of Staff will bear a notation which describes the circumstances under which the record is being filed.

7. Ambulatory Care and Emergency Department Medical Record: Each time a patient visits the Emergency Department or Ambulatory Care, all portions of the previously established medical records at this facility shall be made available upon request to the treating physician. Documentation of services rendered for each visit must include any procedures/tests performed; results of such procedures/tests; pertinent history of illness/injury being evaluated/treated and physical findings including vital signs, as appropriate; diagnostic impression; patient disposition and instructions for follow-up care; immunization status, as appropriate; allergies; referrals and communications to other providers; and an updated problem list. The following additional requirements pertain to documentation in the medical record of emergency services:

a. Patient identification;

b. Time and means of arrival;

c. Emergency care given to the patient prior to arrival;

d. Conclusion at the termination of evaluation/treatment including final disposition, the patient's condition on discharge or transfer and any instructions given to the patient and/or family for follow-up care;

e. Patient departure against medical advice **(if applicable)**.

8. Operating Room Record

a. A preoperative diagnosis will be recorded in the patient's medical record and in the surgical logbook prior to all operative procedures except in case of emergency. If the history and physical examination is not completed and/or recorded before a scheduled operation or potentially hazardous diagnostic procedure, the procedure will be canceled unless such delay would be detrimental to the patient. The medical record shall include a preoperative note which documents the diagnosis, intended surgical procedure and its timing with the documented concurrence by a Medical Staff surgeon. Life threatening emergencies may be exempted and the responsibility rests with the intervening surgeon.

b. Pre-anesthesia evaluation of the patient by an anesthesiologist or designee, with appropriate documentation of information pertinent to the choice of anesthesia and the surgical procedure anticipated, will be entered in the medical record.

c. Documentation of pertinent intraoperative activities or events will be recorded as necessary in the patient record.

d. The anesthesiologist or physician in charge of the Post-Anesthesia Care Unit (PACU) shall determine which patients shall be admitted to PACU care. A member of the Anesthesiology Section will provide a complete report to the PACU nurse and will record condition and vital signs on the Anesthesia Clinical Record. A member of the Anesthesiology Section will evaluate the patient post-anesthetically in order to document the presence or absence of anesthesia-related complications on the Anesthesia Clinical Record and to concur with discharge from PACU care if the Aldrete score is less than eight.

e. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. An operative note will be entered immediately following the surgical procedure using an appropriate progress note title. Operative reports shall be dictated immediately following surgery and the report promptly electronically signed by the surgeon and authenticated once available.

H. INFECTION CONTROL

1. Universal Precautions shall be exercised for all patients admitted to the Hospital and Hospital staff shall follow procedures associated with these precautions. In addition, procedures concerning patients placed in Strict Isolation and/or Respiratory Isolation shall be followed as well. These procedures help reduce the risk of infection in the Hospital for patients and health care workers.

2. The Infection Control Practitioner is the Hospital surveillance officer and has primary responsibility for the required reports to public health agencies and VA Headquarters.

3. The Infection Control Committee, chaired by a Medical Staff member, is responsible to the Clinical Executive Board for establishing and maintaining a program of investigation, surveillance, control and prevention of infections within the Hospital.

I. DISASTERS - The hospital will provide assistance in the event of local or national disasters.

1. In the event of a local disaster, Medical Staff members will report to their assigned post as requested. The triage area will be the urgent care center, unless it has been rendered unusable.

2. The Emergency Management Plan (HPM 589A4-8) will be activated twice a year.

3. National - This hospital is a secondary receiving center to the St. Louis VA Medical Center in the VA/DOD Contingency Plan. Specific roles and responsibilities are defined in the hospital policy.

J. IMPAIRED PROFESSIONAL PROGRAM

1. Purpose

a. The Medical Staff has an obligation to protect its patients from harm, including that which might be caused by an impaired provider. This includes detection of potential problems and referral of the impaired individual for treatment and rehabilitation. Impairments include those caused by physical illness, psychiatric illness, substance dependence, and/or severe interpersonal stress.

b. The Hospital's Employee Assistance Program provides limited counseling and referral services to any employee who has personal problems that affect or have the potential to affect conduct and/or work performance adversely. The program seeks to prevent deterioration in work performance, attendance, and/or conduct that can be a result of such problems as psychological, emotional, marital, financial, and legal or drug/alcohol abuse.

c. The goal of this program is to direct impaired practitioners to treatment and rehabilitation, and avoid disciplinary consequences. Self-referral or directed referral to a treatment program, in itself, will not result in disciplinary action and will not affect compensation or medical staff membership. There may, however, be circumstances, i.e., failure to accept assistance, that lead to corrective action involving clinical privileges and appointment status. Disciplinary action or modification of privileges and/or patient care responsibilities may become necessary to ensure patient safety.

2. Responsibilities

a. Practitioners are responsible for remaining aware of any personal or health problem that may affect their ability to care for patients. They also are responsible for notifying their service line director and seeking treatment should such impairments occur.

b. Practitioners who notice possible impairment in a professional colleague are responsible for ensuring that the issue is dealt with by either persuading the colleague to refer himself/herself for assistance or by informing the service line director.

c. Service line directors are responsible for ensuring patient safety by being aware of any possible problems in their staff's patient care. They are responsible for directing the impaired practitioner to treatment and for following their treatment progress.

d. The Employee Assistance Program provides crisis evaluation of affected individuals and facilitates referral to appropriate and confidential treatment programs.

3. Procedures

a. Self-Referral: A practitioner who perceives possible impairment in his/her performance should discuss the issue with the appropriate service line director. The service line director may need to make changes in clinical duties to ensure that patient care is not adversely affected. Possible actions could include a modification of assignment, back-up coverage, temporary medical leave and, in extreme and persistent cases, a reduction in privileges. The practitioner seeks treatment through the Employee Assistance Program or another source of his/her choice.

b. Supervisory Referral: A service line director who notices or is informed that a practitioner has a possible impairment discusses this with the practitioner and investigates to determine whether the impairment is, in fact, occurring. If it is, the practitioner is counseled to seek treatment. The practitioner may appeal to the Chief of Staff or use the grievance procedure. The Chief of Staff may request the Hospital Director to order a physical or psychiatric examination to determine fitness for duty. Disciplinary action may be taken if the practitioner chooses not to seek treatment.

c. Training: Annual training will be provided to Medical Staff members in regard to this program and identification of staff at risk.

J. UNANTICIPATED OUTCOMES - Patients and, when appropriate, their families, will be kept informed when the care provided differs from that which was intended or planned or was in error. The responsible attending physician or his or her designee will clearly explain the outcome of any treatment or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes. This will be documented in the patient record.