

# BYLAWS RULES & REGULATIONS of the MEDICAL STAFF



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## ***PREAMBLE***

The New Mexico Veterans Affairs Health Care System, hereafter known as NMVAHCS, is a federal health care system, comprised of hospitals and outpatient clinics, operating under the general policies of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA).

As in other VHA facilities, federal law and regulations provide for the legal accountability and responsibility of NMVAHCS and its Medical Staff to the patients they are charged to serve.

In contrast to organizational structures of health care institutions not operated by the federal government, VA Health Care System Medical Staff members are subject to policies and regulations issued by the VHA. As such, the Medical Staff of NMVAHCS does not organize itself, select its own Chief of Staff (COS), elect its Clinical Service Chiefs (CSCs) (equivalent to department chairpersons), nor determine structure and function of some of its main committees. Even so, members of the Medical Staff accept the responsibility for delivering quality patient care within the policies and regulations as required by VHA. Medical Staff decisions affecting organization and process are more in the nature of recommendations to the COS and/or the Governing Body.

The mission of NMVAHCS and its Medical Staff is, as a general medical-surgical-psychiatric-rehabilitation health care institution, with ambulatory care and extended care services, to provide each veteran the highest quality of health care achievable within the limits of the resources granted to NMVAHCS and to provide maximum opportunities in the most favorable environment possible for education and research in biomedical and related fields. In addition to the clinical care, education and research missions, NMVAHCS serves as a back-up medical facility to the Department of Defense in time of national emergency.

The graduate education and training programs and research are supervised and directed by the Health Care System Director (HCSD) through the Medical Staff as reflected in the affiliation agreements;

The Governing body has delegated overall responsibility for the quality of the medical care delivered at the NMVAHCS to the Medical Staff. The Medical Staff is delineated by specific clinical privileges accountable for keeping licensure current, for providing evidence of relevant training and/or experience and maintaining a health status that will not interfere with exercising those clinical privileges.

These Bylaws, Rules and Regulations have been formulated and adopted to describe the professional structure and function of the Medical Staff of NMVAHCS and to permit self-governance to the greatest extent possible, within the operating framework of the policies of NMVAHCS and VHA, in order for the Medical Staff to properly discharge its responsibilities in helping the health care system achieve its mission.

## **DEFINITIONS**

1. HEALTH CARE SYSTEM means New Mexico Veterans Affairs Health Care System. Community Based Outpatient Clinics are located in Artesia, Farmington, Gallup, North West Metro, Raton, Santa Fe and Silver City. Contract Rural Health Clinics are located in Alamogordo, Durango, Espanola, Las Vegas, Taos and Truth or Consequences.
2. GOVERNING BODY is taken to mean the Under Secretary for Health to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration (VHA) of the Department of the Veterans Affairs (VA) of the federal government. For the purpose of local facility management and planning, the Health Care System Director functions as the representative of the Governing Body.
3. The HEALTH CARE SYSTEM DIRECTOR (HCSD), appointed by the Governing Body in consultation with the Secretary of the Department of Veterans Affairs, acts as its agent in the overall administrative management of the health care system and is therefore the "Governing Body" of NMVAHCS. HCSD is responsible to the Veterans Integrated Service Network (VISN) Director and the Under Secretary for Health.
4. ORGANIZED MEDICAL STAFF, the body of Licensed Independent Practitioners (LIPs) with clinical privileges who are collectively responsible for adopting and amending medical staff bylaws (i.e., those with voting privileges as determined by the Facility as defined in these Bylaws) and for overseeing the quality of care, treatment and services provided in the Health Care System.
5. The CHIEFS OF STAFF (COS) at VA health care facilities are appointed by the Under Secretary for Health of the VHA to an indefinite term. They are not elected by the Medical Staff. Their lines of authority, duties and responsibilities are more nearly akin to that of a Medical Director in a non-VA health care system who is appointed by the Governing Body and whose primary responsibility is to the Governing Body.
6. The ASSOCIATE DIRECTOR acts in the capacity of the Chief Operations Officer.
7. The MEDICAL STAFF within the context of these Bylaws, Rules and Regulations is not a self-governing organization of the professional staff but is organized within VHA operational policies so its members may provide the highest quality of care within those policies.

8. The PROFESSIONAL STANDARDS BOARD (PSB) is comprised of licensed independent practitioners with clinical privileges. The PSB serves as the credentialing and privileging committee of the medical staff making recommendations to the Executive Committee of the Medical Staff (ECMS), on issues relating to employment (i.e., credentialing and privileging and special advancement for performance). Oversight of the medical staff is delegated to the PSB.
9. The Executive Committee of the Medical Staff (ECMS) is the executive committee of the NMVAHCS Medical Staff. It is the policy-making committee and is responsible for governance of the Medical Staff in contradistinction to the Governing Body of the health care system as defined in #2 above. The ECMS is chaired by the COS and reports to the HCSD. Its members include: all of the Deputy and Associate Chiefs of Staff and the Clinical Service Chiefs (CSC). Designees or representatives may attend instead of the official member. The HCSD or Associate Director are ex-officio members.
10. The ACADEMIC AFFILIATION PARTNERSHIP COUNCIL is an advisory council to the HCSD. It is established by a formal affiliation agreement between NMVAHCS and the University of New Mexico School of Medicine. Its members are appointed by the HCSD, with input from the COS and the Dean of the School of Medicine, from representatives of the NMVAHCS and the affiliate to consider and advise on development, management and evaluation of all educational and research programs conducted at the facility.
11. STAFF PRACTITIONER as referred to in these Bylaws, Rules and Regulations is a physician (MD or DO), dentist, oral or maxillofacial surgeon, podiatrist, optometrist, clinical psychologist, or Nurse Practitioner/Clinical Nurse Specialist who is fully licensed, or otherwise granted authority to practice independently in any one or more of the States, Territories or Commonwealths of the USA and/or the District of Columbia. These physicians, dentists, podiatrists, oral or maxillofacial surgeons, optometrists, clinical psychologists, and Nurse Practitioners/Clinical Nurse Specialists have met VHA standards for appointment and are thereby granted specific privileges to independently attend to patients and engage in health sciences education and/or biomedical research at NMVAHCS.
12. An APPOINTMENT to the Medical Staff will be based on having an appropriate personnel appointment action to provide patient care services at this Health Care System. This process is distinct from, but may overlap, with that described for the granting of clinical privileges in #13 below.

13. Having CLINICAL PRIVILEGES or being PRIVILEGED means specific permission has been granted to a Medical Staff member to provide patient care services including access to NMVAHCS's (equipment, facilities, personnel, etc.) considered necessary to exercise those privileges.
14. A FUNCTIONAL STATEMENT and/or a SCOPE OF PRACTICE (SOP) is a locally determined statement which describes the duties and responsibilities to be performed and identifies the individual's prescriptive authority, if applicable. A Scope of Practice is appropriate for an allied health professional that is qualified to render direct patient care.
15. The Medical Staff YEAR follows the federal fiscal year commencing October 1 and ending the following September 30.
16. Housestaff: These are physician, dental, podiatric, optometric and clinical psychologist trainees engaged in post-graduate specialty or subspecialty training programs. The term "resident" includes individuals in their first post-graduate year (PGY) 1 of training, often referred to as "interns," and individuals in subspecialty graduate medical education programs, generally referred to as "fellows" (often PGYs 4 and above, depending upon the specialty). "Resident" also refers to individuals designated as "house staff." (VHA Handbook 1400.01) Unless separately credentialed and privileged for independent practice, they practice under the supervision of appropriate members of the Medical Staff also referred to as supervising practitioners, attendings, faculty or staff physicians.
17. MAJOR HIGH-RISK diagnostic or therapeutic interventions are defined as the procedures that require moderate sedation, anesthesia or analgesia, or are likely to produce significant discomfort, morbidity or mortality.

## ***ARTICLE I***                      ***NAME***

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, New Mexico VA Health Care System.

## ***ARTICLE II***                      ***PURPOSE***

### **Section 2.1**                      **The purpose of the Medical Staff is to:**



1. Exercise overall responsibility for the quality of all medical care provided to patients, the ethical conduct and professional practices of its members, and accountability to the COS, HCSD through the ECMS
2. Provide mechanisms that will assure each member is fully qualified at the time of initial appointment and reappointment to the Medical Staff. Assure the granting of specific clinical privileges and when reprivileging to maintain the optimal level of professional performance;
3. Create an atmosphere and framework through the Bylaws, within which each Medical Staff member can accomplish the Medical Staff functions and responsibilities in accordance with the standards set by NMVAHCS, Joint Commission and by regulations of VHA;
4. Ensure that all patients with similar health problems will be provided with the same high level of care throughout NMVAHCS; that care will be delivered in the most appropriate, efficient and timely manner possible whether as an inpatient or outpatient; and that the care given will be subjected to continuous quality improvement practices;
5. Encourage continuous integration of high quality educational programs and advancement of scientific knowledge through research and learning with the goal of continually improving the quality of patient care and continually advancing the professional skills of the Medical Staff.

### **ARTICLE III                      MEDICAL STAFF MEMBERSHIP**

#### **SECTION 3.1                      Eligibility for Membership on the Medical Staff**

1. Membership of the Medical Staff at the NMVAHCS carries a similar degree of responsibility when compared to non-VA health care facilities. Being on the Medical Staff at NMVAHCS is a privilege extended only to professionally competent physicians, dentists, oral or maxillofacial surgeons, podiatrists, optometrists and clinical psychologists who continuously meet the qualifications, standards, policies and requirements of NMVAHCS, these Bylaws and its Rules and Regulations and the regulations of VHA. Membership may be extended to other licensed practitioners, including Nurse Practitioners and Clinical Nurse Specialists who are permitted by law to provide patient care services independently and who meet the qualifications, standards and requirements of the Bylaws, Rules and Regulations of NMVAHCS and VHA Handbook 1100.19 (2012).

2. No physician, dentist, oral or maxillofacial surgeon, podiatrist, optometrist, or clinical psychologist, including those in administrative or research positions, shall by virtue of a contract with NMVAHCS alone, admit or provide medical or health-related services to patients at the NMVAHCS unless granted emergency, temporary or full privileges in accordance with the procedures in these Bylaws.

## **SECTION 3.2                      Qualifications of Medical Staff Membership**

1. Only those physicians, dentists, oral or maxillofacial surgeons, podiatrists, optometrists and clinical psychologists qualify who:
  2. Meet the general qualifications for membership set forth and have the appropriate employment status as defined by VHA regulations;
  3. Have residences or have made living arrangements while on call, which in the opinion of the ECMS, are close enough to NMVAHCS to provide appropriate continuity of care.
  4. Possess an active, current, full, unrestricted license to practice medicine, dentistry, oral or maxillofacial surgery, podiatry, optometry or clinical psychologists, in one of the States, Territories, or Commonwealths of the USA or the District of Columbia as required for employment by VHA;
  5. Document and provide copies of the needed original certificates or letters of support or signed statements to demonstrate qualifications
  6. Proof of US citizenship. A non-citizen must provide a valid visa and proof of qualification for a temporary appointment;
  7. Evidence of professional education, training and subsequent experience as being appropriate and acceptable for the position under consideration;
  8. Current professional competence, sound judgment, and ability to work cooperatively with others so as not to adversely affect patient care;
  9. Sufficient physical and mental health so as not to compromise their professional and ethical competence thereby assuring that patients treated by them can reasonably expect to receive high quality medical care;

10. The ability and willingness to adhere to the ethics of their respective professions including commitment to keep confidential all information and records received in the provider-patient relationship, as required by law.
11. The ability and willingness to participate and properly discharge responsibilities as determined by the HCSD, the COS, the ECMS, VHA regulations and JCO standards, including participating in Quality Management activities.
12. In order for unlimited licensed practitioners, (MDs and DOs) to be on the Medical Staff they must hold a degree of doctor of medicine or osteopathy or its equivalent from a school approved by VHA's Under Secretary for Health for the year in which the course of study was completed.
13. Limited licensed practitioners on the medical staff (dentists, oral or maxillofacial surgeons, podiatrists, optometrists and clinical psychologists, nurse practitioners and clinical nurse specialists) must hold the appropriate degree conferred by a school approved at the time of issuance by VHA's Under Secretary for Health for the year in which the course of study was completed.

### **SECTION 3.3                      Nondiscrimination**

1. The professional criteria cited above under Article III, section 3.2 will be uniformly applied to all applicants or members and shall constitute the basis for the granting of clinical privileges without discrimination for such reasons as sex, race, creed, national origin, age, marital status, membership or non-membership in a labor organization, lawful partisan, political affiliation, or for reason of any physical disability, when the disabled employee is otherwise qualified and capable of providing high quality patient care and treatment.
2. Code of Conduct:
  - a. Acceptable Behavior:
    - (1) The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following:  
  
(2) being on duty as scheduled.

- (3) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization,
- (4) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA,
- (5) not making a governmental decision outside of official channels,
- (6) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and
- (7) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

3. Behavior or Behaviors That Undermine a Culture of Safety:

- a. VA recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. VA strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that it could affect or potentially may affect, quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact.
- b. is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul

language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that Behavior or Behaviors That Undermine a Culture of Safety is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, Behavior or Behaviors That Undermine a Culture of Safety may reach a threshold such that it constitutes grounds for further inquiry by the ECMS into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action.

4. VA distinguishes Behavior or Behaviors That Undermine a Culture of Safety from constructive criticism that is offered in a professional manner with the aim of improving patient care. VA also reminds its providers of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a provider's health and performance. Providers suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.
5. Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing Behavior or Behaviors That Undermine a Culture of Safety on the part of other providers. VA urges its providers to support their hospital, practice, or other healthcare organization in their efforts to identify and manage Behavior or Behaviors That Undermine a Culture of Safety, by taking a role in this process when appropriate.
6. Professional Misconduct: Behavior by a professional that violates or appears to compromise ethical standards.

## **SECTION 3.4                      Conflict Resolution & Management**

For VA to be effective and efficient in achieving its goals, the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution*

*Program*, addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. This mechanism can be utilized to manage conflict between the Executive Committee and the Organized Medical Staff on issues including, but not limited to proposals to adopt a rule or regulation or policy or amendment thereto. Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Governing Body (Director) on a rule, regulation or policy adopted by the Organized Medical Staff or the Executive Committee. The Governing Body (Director) must determine the method of this communication. VHA expects VA medical center leadership to make use of these and other resources in communicating expectations to clinicians and other staff that conflictive, disruptive, inappropriate, intimidating, and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff who experience or witness such behavior are encouraged to advise an appropriate supervisor, Patient Safety Officer, or other individuals as needed.

## **ARTICLE IV                      ORGANIZATION OF THE MEDICAL STAFF**

### **SECTION 4.1                      Appointment of Medical Staff Officers**

1. In NMVAHCS there are no "elected officers" of the Medical Staff. The COS and the CSCs are appointed to indefinite terms. Appointments of COSs are submitted to VHA for information and comment; the COS's appointment must be approved by the Under Secretary for Health. Appointments are based on qualifications, training, and experience. The COS appointment is for an indefinite period.
2. In NMVAHCS, the COS is the equivalent of the "Medical Director" or "Chief of the Medical Staff" and must be a member of the Medical Staff.

### **SECTION 4.2                      Duties and Responsibilities of the Chief of Staff (COS)**

1. The COS will actively participate in and support the health care system's performance improvement activities. The COS will ensure clinical services' involvement in these activities as well.
2. The COS shall serve as the Chief Executive Officer of the Medical Staff, organizing and presiding at meetings of the Executive Committee of the Medical Staff (ECMS), Clinical Executive Board (CEB), Professional Standards Board (PSB) and annual meetings of the Medical Staff, and assure that the various other Medical Staff

Committees and services are functioning in accordance with these Bylaws, Rules and Regulations.

3. The COS shall act as full assistant to the HCSD and collaborate with the Associate Director in the planning, direction, coordination and supervision of administrative activities inherent in the care of patients, in providing allied health services, and in research and educational activities.
4. The COS shall enforce these Bylaws, applicable VHA regulations and health care system policies, taking corrective action as indicated.
5. The COS shall supervise and/or participate in the appointment and periodic reappraisal of members of the Medical Staff and allied health care staff, including credentialing and delineation of clinical privileges.
6. The COS shall represent the views, policies, needs and grievances of the Medical Staff to the ECMS and to the HCSD.
7. The COS shall receive and interpret the policies of the ECMS to the Medical Staff and report to the governing body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.
8. The COS shall represent the medical staff at the VISN level.

#### **SECTION 4.3                      Clinical Services**

1. The Medical Staff is organized to carry out services under leadership of the clinical service chiefs. Each of the services/programs has a service chief/director, accountable to the COS. Each staff member shall be assigned to a specific service.
2. Each service will hold regularly scheduled meetings at least quarterly. They must be sufficiently frequent to carry out these functions:
3. Provide for continuous quality improvement within the service including consideration of findings of ongoing monitoring and evaluation of quality (including access, efficiency, safety and effectiveness); appropriateness of care and treatment provided to patients (including that provided by providers with temporary or emergency privileges); patient satisfaction activities; risk management activities; and utilization management;

4. Assist in identifying important aspects of care for the service, identification of indicators used to monitor quality and appropriateness of important aspects of care.
5. Maintain records of meetings that include conclusions, recommendations, actions taken, and evaluations of actions taken. Minutes from these meetings are transmitted to the CEB as appropriate;
6. Develop criteria for recommending clinical privileges for service members;
7. Develop policies and procedures to assure effective management, ethics, safety, communication and quality within NMVAHCS.

#### **SECTION 4.4                      Clinical Service Chief (CSC) Responsibility of Appointments**

1. CSCs are qualified for their position by training, experience, and administrative ability, and shall be appointed for an indefinite period. CSCs must have certification by an appropriate specialty board or established comparable competence through the credentialing process. CSCs are appointed by the HCSD based on recommendations of the COS and with input by representative(s) from UNM (when appropriate). Responsibilities of CSCs shall include:
  - a. Accountability to the COS and the HCSD for all professional and Medical Staff administrative activities within the service, including selection, orientation and continuing education of the staff of the particular service;
  - b. Continuing surveillance of the professional performance of members of the Medical Staff who exercise privileges in their service, including recommendations on each member at the time of reappraisal;
  - c. Recommending to the PSB the criteria for granting privileges in the service and for recommending specific clinical privileges for each member of the service and others requesting privileges within the service;
  - d. Assuring that regular review and evaluation of the quality and appropriateness of patient care rendered within the service (including clinical work performed by staff members with privileges in the service who are assigned to another service) are carried out, documented, and reported in accordance with the health care system's Quality Management initiatives, VHA's Health Services Review Organization-Systematic Internal Review Program and, when applicable, Joint Commission standards;
  - e. Assuring the participation of service staff members in appropriate continuing education programs and required meetings;
  - f. Appointing committees, as needed, to conduct service functions;



- g. Participating in budgetary and staffing planning for the service, providing input for NMVAHCS's overall budgetary planning and providing information or assistance for preparation of reports required by VHA and/or health care system policy;
- h. Serving on the ECMS, CEB, PSB and other committees as designated by the COS, and communicating actions taken by such committees to staff members of the CSC's service;
- i. Designating appropriate service staff members to serve on Medical Staff committees commensurate with their clinical qualifications as requested by the ECMS, CEB, the COS or the HCSD and assuring their attendance and participation;
- j. Representing service staff members at the HCSD's staff meetings and communicating items discussed to the service staff;
- k. Taking or recommending actions necessary to assure service staff compliance with the Medical Staff Bylaws, Rules and Regulations as well as NMVAHCS and VHA regulations and service policies, and assuring rules and regulations of the various services do not conflict with each other;
- l. Coordinating the service's patient care activities with ancillary and administrative support services;
- m. Fostering an atmosphere of professional decorum within the service appropriate to the healing arts;
- n. Assessing and recommending to the COS off-site sources needed for patient care services not provided or not accessible on-site;
- o. Ensuring the integration of the service into the primary functions of the organization and ensuring the coordination and integration of intradepartmental and interdepartmental services;
- p. Recommending a sufficient number of qualified and competent personnel to provide care or service;
- q. Determining the qualifications and competence of service personnel, who are not independent practitioners, who provide patient care service;
- r. Maintaining quality improvement programs as appropriate;
- s. Assuring the initial orientation and continuing education of all persons in the service;
- t. Recommending space and other resources needed by the service.
- u. Reaching and maintaining current written agreements on the amount of time allotted for clinical, administrative, research and educational activities for physicians assigned to the Service.
- v. Establishing employee work schedules and adjusting those schedules to meet patient care and other work requirements. This includes adjusting work

schedules to accommodate employees' needs, provided the adjustments do not adversely affect the care and treatment of VA patients.

#### **SECTION 4.5                      Active Medical Staff**

1. The Active Medical Staff have full time or part-time appointments. VHA Human Resources are responsible for all organizational and administrative duties pertaining to the Medical Staff. Only those active Medical Staff that are full-time and 4/8ths time or greater may vote and have attendance requirements at Medical Staff meetings.
2. The following Practitioners will be credentialed and privileged to practice independently:
  - a. Physicians
  - b. Dentists
  - c. Oral or Maxillofacial Surgeons
3. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license / registration that permits independent practice and is authorized by this facility:
  - a. Optometrists
  - b. Podiatrists
  - c. Clinical Psychologists

#### **SECTION 4.6                      Medical Staff Category Definitions**

1. The Medical Staff at NMVAHCS is categorized in two ways, namely by employment status and by function. Employment status alone does not confer Medical Staff membership although it may influence it.
2. By employment status the Medical Staff members (physicians, dentists, oral or maxillofacial surgeons, podiatrists, optometrists and clinical psychologists) are classified into: permanent full-time, temporary full-time, part-time, intermittent, consultant, and attending, fee basis, without compensation, on-station fee basis, on-station contract, or on-station sharing agreement.
3. By function, members of the Medical Staff are appointed as:
  - a. Active staff may be employed permanent full-time, part-time, temporary full-time or intermittent;

- b. Medical staff are employed under Title 38 or Hybrid Title 38. Termination of employment results in automatic termination of appointment to the Medical Staff unless requested by the CSC to convert to another status, (e.g., Consultant, Fee Basis, etc.).

## **SECTION 4.7                      Active Staff**

1. Medical staff members holding administrative positions, e.g., CSCs and the COS, are subject to actions by the PSB and/or ECMS in the same manner as all other medical staff members. Active medical staff perform all significant medical staff organizational and administrative functions consistent with these Bylaws, Rules and Regulations, VHA regulations, and other NMVAHCS policies. Consultants and Attendings are members of the active medical staff who supplement the full-time, part-time and intermittent staff members in their roles in patient care, education and research. The credentialing and privileging process is the same as for other members. However, because of extensive responsibilities at their primary institutions, in most cases Consultants and Fee-Basis physicians are not required to attend the same percentage of service meetings nor provide the same service on committees as full-time staff.
2. PREROGATIVES: Except as otherwise provided within these bylaws, the prerogatives of an active staff member shall be to:
  - a. Exercise such clinical privileges as are granted pursuant to Article VIII;
  - b. Attend and have the right to vote, within the constraints of VHA regulations and commensurate with these Bylaws, Rules, and Regulations, and other policies of NMVAHCS, on matters presented at general and special meetings of the Medical Staff and to serve on committees of which the medical staff member is an appointed member.

## **SECTION 4.8                      Housestaff**

1. The Housestaff are in a special category of the Medical Staff and shall consist of those individuals who are graduates of medical, osteopathic, dental, optometric, podiatric or psychology schools and who are engaged in a formal program of postgraduate training and education at NMVAHCS, whether their employment contract is with or without compensation. They are recommended for their appointment by the Associate Dean of Graduate Medical Education at the University of New Mexico School of Medicine and/or the Associate Chief of Staff (ACOS) for Education & Academic Affiliations at the NMVAHCS. They are subject

to the regulations of VHA for the VA portion of their training. They are not subject to a determination of clinical privileges except as noted below in paragraph 4.8.2. They function only under the supervision of and within the clinical privileges granted to the medical staff member who has clinical privileges in the area being supervised. Unless specifically included as a voting member, Housestaff will serve as ex-officio members on designated health care system committees.

2. When a resident or fellow is in the advanced years of training, or is a Chief Resident who normally supervises more junior residents, or is to function outside of the normal training assignment, e.g., is hired to cover the Emergency Department as an independent practitioner, the resident or fellow must go through the credentialing and privileging process and become a member of the Medical Staff.

## **SECTION 4.9                      Affiliates of the Medical Staff**

**ALLIED HEALTH PROFESSIONALS (AHP)** Allied health professionals are affiliates of the Medical Staff and as such they are not members of the Medical Staff.

1. **GENERAL:** Many different professionally trained people contribute their unique skills to the direct care of patients. Their activity is under the general supervision or direction of medical staff members. These individuals are generally, and for the purposes of these Bylaws, designated as Allied Health Professionals (AHPs). They shall be affiliate members of the Medical Staff and include (but are not limited to) the following:
  - a. Audiologist
  - b. Certified Registered Nurse Anesthetist
  - c. Certified Nurse Practitioners
  - d. Clinical Nurse Specialists
  - e. Certified Diabetic Educator (CDE)
  - f. Clinical Pharmacist Specialist (CPS)
  - g. Clinical Social Worker
  - h. Dental Assistants
  - i. Dental Hygienist
  - j. Doctor of Pharmacy (PharmD)
  - k. Dietitian
  - l. Physician Assistant (PA)
  - m. Psychologist (Master's Level)
  - n. Speech Pathologist
  - o. Occupational Therapists
  - p. Physical Therapists

2. QUALIFICATIONS OF AHP's: Allied health professionals shall be subject to the qualification requirements contained in VHA and/or Office of Personnel Management regulations. Their responsibilities may be described in a position description, under a scope of practice, or in a functional statement. Training, experience, and current and continuing competence qualify them as allied health professionals and shall be sufficient to permit them to:
  - a. Exercise judgment within their areas of competence, providing that a member of the Medical Staff shall have the ultimate responsibility for patient care;
  - b. Participate directly in the management of patients under the supervision or direction of a physician member of the Medical Staff;
  - c. Make entries in patients' medical records within the limits established by the Medical Staff;
  - d. Prescribe medications under the supervision of a physician member of the Medical Staff; this applies only to appropriately approved, PharmDs, CRNAs, NP/CNS who have not requested/been granted prescribing authority, CPSs and PAs.
3. APPOINTMENT OF AHPs: Allied Health Professionals shall be appointed in accordance with these Bylaws and the HCSDMs relevant to AHPs.
4. RESPONSIBILITIES OF AHPs: Each allied health professional shall:
  - a. Meet the basic requirements of the appropriate position description, scope of practice or functional statement;
  - b. Retain appropriate responsibility, within the areas of professional competence for the care and supervision of patients assigned or arrange a suitable alternative for such care and supervision;
  - c. Attend meetings of the assigned service, serve on health care system or medical staff committees as designated, and participate as appropriate in the Quality Management initiatives of this health care system;
  - d. Supervise professional appointees of the same profession, as appropriate;
  - e. Discharge other staff functions as may be required from time to time by the Medical Staff, CSC, COS or HCSD;
  - f. Allied health professionals shall be individually assigned to the appropriate service(s) at NMVAHCS and shall carry out their activities subject to the policies and procedures of NMVAHCS;
  - g. Allied health professionals who have duties that constitute the practice of medicine (e.g., ordering diagnostic tests or procedures, writing prescriptions including for "over the counter" medications, administering regional or general

anesthesia, suturing or debridement of wounds, etc.) require a scope of practice that is signed by a physician supervisor and reviewed at least every two years.

## **ARTICLE V                      COMMITTEES AND BOARDS**

### **SECTION 5.1                      Standing Committees**

1. Standing committees shall be appointed by the HCSD on recommendation by the COS. Each committee will designate an individual to be responsible to prepare and maintain reports of conclusions, recommendations, actions taken and effectiveness of actions taken. Committee reports will be forwarded in a timely manner through appropriate channels established by the ECMS or by the HCSD.
2. All committees are charged with the duty of assuring that members of the Medical Staff comply with VHA and Joint Commission requirements applicable to their area of responsibility, including peer review. Their function and purpose, chairpersonship, membership and quorum requirements and organization are described in specific HCSMs.

### **SECTION 5.2                      The Executive Committee of the Medical Staff**

1. Characteristics: The Executive Committee of the Medical Staff (ECMS) serves as the Executive Board of the Medical Staff. The members of the ECMS are:
  - a) Chief of Staff, Chairperson, voting.
  - b) Deputy Chief of Staff, voting
  - c) Associate Chiefs of Staff, voting
  - d) Clinical Service Chiefs, voting.
  - e) Director, or designee, non-voting.
  - f) The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
2. Medical Staff members of the ECMS are selected for membership by virtue of their appointment to their VA positions. Associate Chiefs of Staff and Service Chiefs are appointed or removed by the Director based upon the recommendation of the COS. Other facility staff may be called upon to serve as resources or attend committee meetings at the request of the chairperson, with or without vote

### **SECTION 5.3                      Functions and Responsibilities of the ECMS**

1. The ECMS: The ECMS shall act for the Medical Staff between Medical Staff meetings including endorsing the revision of all medical center memoranda, standing operating procedures, interpretation and means of implementation of the Bylaws. Revisions to the Bylaws will be made as urgent amendments to Rules and Regulations necessary to comply with law or regulation may be provisionally adopted by the ECMS and approved by the Director without prior notification to the Medical Staff. In such cases, the COS, acting on behalf of the ECMS will notify the active Medical Staff. The revision will be formally adopted at the next scheduled Medical Staff meeting. The Medical Staff may redress concerns regarding such revisions dealing with the process for reviewing credentials, delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process.
  - a. Acts to ensure effective communications between the Medical Staff and the Director.
  - b. Makes recommendations directly to the Director regarding the:
    - (1) Organization, membership (including termination of membership), structure, and function of the Medical Staff. Termination of Medical Staff membership does not include recommendations of termination of employment which should be managed through VHA HR Handbook 5021 established policies.
    - (2) Developing and following through on fair hearing procedures in accordance with these Bylaws and recommending termination of Medical Staff membership;
    - (3) Process used to review credentials and delineate privileges for the Medical Staff.
    - (4) Delineation of privileges for each Practitioner credentialed.
  - c. Reviewing the recommendations of the PSB and making recommendations to the COS and HCSD regarding staff appointments and reappointments, assignments to services, determining initial and renewal of clinical privileges, and recommending corrective action when necessary;
2. Annually reviews and makes recommendations for approval of the Service-specific privilege lists.
3. Taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all medical members including the initiation of and participation corrective or review measures when warranted;
4. Reviewing and revising the Bylaws, Rules and Regulations of NMVAHCS whenever administrative or practice patterns differ significantly from those recorded here;

5. Convening a subcommittee to recommend and monitor treatment for Medical Staff members who have health issues that require treatment but do not necessarily require any limitations on clinical privileges or disciplinary action. An individual Medical Staff member who believes that another member is providing unsafe treatment is obligated to relate these concerns to the service chief of the medical staff member in question and to the Chief of Staff. In some cases, this may be due to the physician in question having a health impairment. To help prevent members from suffering from a potentially impairing condition, all staff are encouraged to make use of the services provided by Employee Health and the Employee Assistance Program (EAP) to obtain information about their health and to get information about prevention of physical, psychiatric or emotional illness. When the CSC is aware of a member with such concerns, the CSC is expected to facilitate confidential diagnosis, treatment and rehabilitation of medical staff members who suffer from a potentially impairing condition. If at any time in the diagnosis, treatment or rehabilitation phase of the process it is determined that a medical staff member is unable to safely perform the privileges granted, the matter is forwarded to the COS to evaluate the credibility of the matter of concern and if appropriate the matter is conveyed to a subcommittee of the ECMS for any corrective action including adherence with mandated reporting requirements. The COS will decide whether to implement or modify the recommendations of the ECMS subcommittee based primarily on an assessment of whether they are sufficient to help assure that the medical staff member continues to receive appropriate treatment and monitoring. Failure to comply with rehabilitation recommendations may result in disciplinary action.
6. Oversees process in place for instances of “for-cause” concerning a Medical Staff member’s competency to perform requested privileges.
7. Oversees process by which membership on the Medical Staff may be terminated consistent with applicable laws and VA regulations.
8. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.
9. Monitors Medical Staff ethics and self-governance actions.

#### Meetings

1. Regular Meetings: Regular meetings of the ECMS shall be held at least monthly. The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chairs of the various committees of the Medical Staff shall attend regular meetings of the ECMS when requested to report on the activities and recommendations of their



committees; and may attend at other times with the consent of the COS. Such attendance shall not entitle the attendee to vote on any matter before the ECMS.

2. **Special Meetings:** Special (emergency) meetings of the ECMS may be called by the COS to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any special meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at a special meeting. In the event that the COS is not available to call a special meeting of the ECMS, the Acting Chief of Staff or the Director as the Governing Body may call a special meeting of the Committee.
3. **Meeting Notice:** All ECMS members shall be provided at least a one (1) day advance notice of the time, date, and place of each regular or special meeting.
4. **Agenda:** The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.
5. **Quorum:** A quorum for the conduct of business at any regular or special meeting of the ECMS shall be:
  - a. the COS or Deputy Chief of staff or the Acting COS; AND
  - b. the Director or Director's representative; AND
  - c. a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present. The majority of the voting members must be fully licensed physicians of medicine or osteopathy. The definition of quorum cannot be waived.
6. **Minutes:** Written minutes shall be made and kept on all meetings of the ECMS, and shall be open to inspection by members of the Medical Staff.
7. **Communication of Action:** The Chair at a meeting of the ECMS at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.
8. **The ECMS may appoint subcommittees with specific functions, which may have representatives other than members of the Medical Staff.**

## **SECTION 5.4**

### **The Clinical Executive Board (CEB)**

1. Characteristics: The Clinical Executive Board (CEB) serves as the representative body of the clinical and patient care services.
2. Coordinates the ongoing review and evaluation of quality improvement activities and ensures full compliance with VHA Clinical Performance Measures, The Joint Commission, and relevant external standards.
3. The members of the CEB are:
  - a. The COS as the Chairperson.
  - b. Members of the Medical Staff and AHPs are eligible for membership on the CEB. Membership follows recommendation of the COS for approval by the Governing Body. Voting members of the CEB shall include the Deputy Chief of Staff, Associate Chiefs of Staff, the CSCs, the ADPCS and the Allied Health Service Chiefs. At meetings of the CEB, voting members who are not able to attend should designate alternates who may vote in their place. The COS may select two additional representatives from the Medical Staff as nominated by their CSC for a two-year term as a voting member of the CEB at the time of the annual meeting of the Medical Staff.
4. Functions and responsibilities of the CEB: The functions and responsibilities of the CEB, as also delineated in health care system policies and procedures, shall include, but are not limited to:
  - a. Receiving and acting on reports and recommendations from services and committees of the Medical Staff and other ad hoc committees as appropriate;
  - b. Recommending actions to the ECMS, regarding matters of a medical-administrative nature;
  - c. Establishing mechanisms for recommending to the HCSD the initiation or pursuit of corrective action when warranted;
  - d. Considering and preparing recommendations for matters relevant to the operation of an organized staff;
  - e. Fulfilling the Medical Staff's accountability for the quality of the overall medical care rendered to the patients in NMVAHCS and monitoring the level of care provided across services by clinically privileged individuals;
  - f. Participating in the development of Medical Staff and NMVAHCS policy, practice and planning;
  - g. Advising facility leadership and coordinating activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.

- h. Assisting in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.
  - i. Reviewing the need for and formulating priorities for continuing education activities and programs for the Medical Staff in accordance with VHA and State regulations, with the Associate Chief of Staff for Education & Academic Affiliations;
  - j. Designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and working closely with the COS when appointments are made to these committees;
  - k. Disseminating recommendations for the protection and care of patients and others in the event of internal or external disasters;
  - l. Consulting with the COS in appointing such special or ad hoc committees as may seem necessary or appropriate to assist the CEB in carrying out its functions and those of the Medical Staff;
  - m. Reviewing the quality and appropriateness of services provided by contract physicians;
  - n. Reviewing and recommending approval of system-wide MCMs to the HSCD;
  - o. Assuring the participation of Medical Staff in the organization's performance improvement activities.
5. Meetings of the CEB:
- a. The CEB will meet a minimum of ten times per year or more often if necessary to accomplish its duties. Special meetings of the CEB may be called at any time by the HCSD, the COS or by a majority of the membership of the CEB.
  - b. Members of the CEB or their designated alternates must be in attendance at a majority of its regularly scheduled meetings.

## **SECTION 5.5 Professional Standards Board**

- 1. Characteristics: The Professional Standards Board (PSB) serves as the Credentials Committee for credentialing and clinical privileging matters of the Medical Staff.
- 2. The members of the PSB are:
  - a. The Chairperson of the PSB is the COS.
  - b. Membership of the PSB shall include all the CSCs.
  - c. The Chief or designee of HRMS will serve as a resource to the PSB for the purpose of establishing the wage grade and to advise and ensure proper procedures are followed in processing the appointment for employment.

- d. A Credentialing Specialist will be an ex officio member for the purpose of advising, assisting and presenting proper credentialing, privileging and any other required documents to the board.
3. Functions and Responsibilities of the PSB are:
- a. Serves as the credentialing body for the Medical Staff, as described in these Bylaws and, as provided in VHA Directive 1100.19, shall also serve as the Professional Standards Board for non-LIP disciplines. In the case of non-physician Medical Staff members, the Program Director of the respective discipline shall also be present for credentialing and appointments.
  - b. The members of the Professional Standard Board also serve as members of the Physical Standards Board and shall review the results of medical examinations of members of the Medical Staff requested by the CSC and/or the COS. They shall recommend to the HCSD, through the COS, the appointment to the Medical Staff or the separation from it, for disability, when indicated. The chair shall be the same as that of the Professional Standards Board except when an unusual or special medical problem is under consideration and the COS wishes to designate physician(s) with appropriate expertise to supplement the membership. The Physical Standards Board shall meet at the call of the Chairperson. A quorum will consist of at least three physicians in addition to the chief of the particular service to which the member with the medical problem under consideration belongs.
4. Meetings:
- a. Meetings of the PSB shall occur monthly or at the call of the Chairperson.
  - b. A quorum will consist of the Chairperson or designee and at least two other members.
  - c. Reports of committee recommendations will be sent to the ECMS and HCSD for review and action.

## **SECTION 5.6                      General Medical Staff Meeting**

1. The function and purpose of the general Medical Staff Meeting is to:
- a. Receive the annual report by the HCSD on the state of NMVAHCS and review and approval of the NMVAHCS Bylaws.
  - b. Receive comments by medical staff members on overall Medical Staff activities including current problems affecting the delivery of patient care and implemented or planned corrective actions;
  - c. The meeting is held annually. Special meetings may be called at any time by the HCSD, COS or ECMS;

- d. Attendance at the regular annual meeting and any special meetings of the Medical Staff is required. A quorum shall consist of a number equal to fifty percent (50%) of the active medical staff; a majority vote of those present is required to approve any motions.

## **ARTICLE VI**

## **ETHICS AND ETHICAL RELATIONSHIPS**

### **SECTION 6.1**

### **General Ethical Considerations**

1. All members of the Medical Staff will deliver patient care according to ethical practices outlined by VHA, the American Medical Association, the American Dental Association, the American Osteopathic Association, the American Podiatric Medical Association, the American Optometric Association or the American Psychological Association whichever is appropriate.
2. All members of the Medical Staff will follow the Advanced Health Care Planning and Management of Advance Directives and Informed Consent for Clinical Treatment and Procedures process as outlined in MCM 1121 and MCM 11-22. Problematic ethical issues or concerns regarding advance directives, life-sustaining treatment decisions including DNR orders, or informed consent should be referred to the Ethics Consultation Service.
3. All members of the Medical Staff are responsible for protecting patients from an impaired provider and for assisting an impaired colleague. Concerns regarding an impaired provider (whether the source of the impairment is due to alcohol or other substances, physiological, psychiatric or behavioral disorders, or diseases that affect cognitive or motor skills required to provide adequate care) should immediately be brought to the attention of the Chief of Service and the Chief of Staff. It is the responsibility of the institution, not the individual employee or member of the medical staff, to report impaired providers to the New Mexico Medical Board.

### **SECTION 6.2**

### **Full-time Appointments and Outside Professional Activities Restrictions**

According to VA regulations, no full-time member of the Medical Staff may tender professional service for remuneration to any patient hospitalized or treated at VHA expense in a non-VA hospital, clinic, or other health care facility. Full-time professional staff who engage in outside professional activities for remuneration must scrupulously avoid creating any situation or circumstance where it might be implied that the

employee, because of outside activity, is not meeting the full requirements and responsibilities of the VHA position. Consequently, Title 38 or Hybrid Title 38 VHA full-time professional staff members who engage in outside professional activities for remuneration will be required to perform a scheduled tour of duty of 80 hours per pay period while so involved and meet other patient care needs which require their attendance beyond the scheduled tour of duty.

## **ARTICLE VII                      COMMUNICATION WITH THE HCS DIRECTOR**

### **SECTION 7.1                      Effective Communication**

1. To assure effective communication between the Medical Staff and the HCSD, particularly with reference to the quality of patient care and any health care system deliberations that affect the discharge of Medical Staff responsibilities, the following mechanisms shall be established:
  - a. Health Care System Director's Staff Meetings: In addition to the COS, the Associate Director, Deputy and Associate Chiefs of Staff, CSCs, Allied Health Service Chiefs and Administrative Service Chiefs are encouraged to attend this monthly staff meeting. The staff meeting shall provide a forum for discussion of budgetary, workload, and other health care system matters affecting the discharge of Medical Staff responsibilities.
  - b. Leadership and Performance Board: The function and purpose of the Leadership and Performance Board (LPB) is to serve as an advisory body to the HCSD. It is established to assure the integration and coordination of health care system operations, policies, quality management activities, and plans. It is chaired by the HCSD and meets at the discretion of the HCSD.
  - c. Reports: Reports required by VHA or VA regulations for submission to VA Central Office and minutes shall be forwarded to the HCSD on a regular basis as specified in these Bylaws. In addition, the CSCs may communicate problems or suggestions for the correction of identified or potential problems to the HCSD through the COS at any time.

## **ARTICLE VIII                      APPOINTMENT AND ONGOING CREDENTIALING**

### **SECTION 8.1                      General**

1. All potential members of the Medical Staff who expect to hold clinical privileges will be subjected to full credentials review at the time of appraisal for initial appointment

and will be fully reappraised at the time of reprivilaging every 2 years. Similar review will be made for the initial granting of clinical privileges and after a break in VA service of more than 15 workdays as outlined in this Article. Credentials that are subject to change during leaves of absence will be subjected to review at the time the individual returns to duty.

2. Except, as otherwise specified, no one shall exercise any clinical privileges in this health care system until that person becomes a member of the Medical Staff as set forth in these Bylaws. By applying for privileges, the applicant acknowledges responsibility to review these Bylaws, Rules and Regulations and accept the responsibilities of being a Medical Staff member and comply with the Bylaws, Rules and Regulations as they exist and as they may be modified. Only such clinical privileges that have been granted may be exercised.
3. Appointments to the Medical Staff are conditional pending appointments to VA service or completion of contractual agreements for medical services. The authority for these appointments are based upon:
  - a. Provisions of 38 U.S.C. in accordance with VA, VA Handbook 5005, Part II and applicable Agreement(s) of Affiliation in force at the time of appointment;
  - b. Provisions of federal and VA acquisition requirements for scarce medical specialty contracts;

## **SECTION 8.2                      Period of Appointment**

Initial appointments to VA employment made under authority of 38 U.S.C. 7401 (1) and 7405 (a) (1) are made in accordance with regulations stated in VA Handbook 5005, Part II, Chapter 3. Only full-time permanent appointments of physicians, dentists, oral or maxillofacial surgeons, podiatrists, optometrists and clinical psychologists are made under authority of section 38 U.S.C. 7401 (1). These appointments are subject to a two-year probationary period requirement. Temporary full-time appointments are made under authority of section 38 U.S.C. 7405 (a) (1). Temporary full-time appointments may be made for any period up to 3 years. Such appointments may be renewed, but the aggregate period of temporary service normally will not exceed 6 years. The HCSD may grant exceptions to permit renewals beyond 6 years when this type of appointment best meets the needs of the VA medical program. During this time, the appointee's professional competence, professional performance and professional conduct will be evaluated by the appropriate CSC, the COS and the PSB. If the applicant has demonstrated an acceptable level of performance and conduct, permanent appointment may be granted.

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

### **SECTION 8.3                      Burden of Producing Information**

In connection with all applications for appointment and reappointment, the applicant, shall be responsible for producing the information required for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges requested, for resolving any reasonable doubts about these matters and for satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a physical examination and may include a psychological examination if deemed appropriate by the PSB.

### **SECTION 8.4                      Appointment Authority**

Appointments, denials and revocations of appointments to the Medical Staff shall be made by the HCSD, upon recommendation from the ECMS.

### **SECTION 8.5                      Application Procedure and Required Documents**

1. All applicants will:
  - a. Sign a "Consent for the Release of Information" permitting VHA to obtain information from past employers, schools, etc.;
  - b. Allow for inspection by health care system representatives of pertinent records and documents that are material to an evaluation of the applicant's professional and ethical qualifications and ability to carry out the clinical privileges requested;
  - c. Grant permission for consulting by health care system representatives with others who have been associated with the applicant and/or who may have information bearing on the applicants competence and qualifications;



- d. Sign an ethical pledge to abide by practices described in Article VI and such other forms and certifications required by VHA regulations;
- e. Provide any information regarding current professional liability insurance and any past or present involvement in professional liability action, whether any claim has been made against the practitioner in the practice of any health occupation and the status of the claim, whether a complaint or report has been filed with any state medical licensing or disciplinary agency such as a local or state medical society, state disciplinary body, professional or specialty association, or state/federal agency;
- f. Be prepared to submit to random drug testing;
- g. Comply fully with the policy and procedures of the VHA Handbook 1100.19 titled "Credentialing & Privileging."
- h. Each applicant shall be provided a current copy of the Medical Staff Bylaws, Rules and Regulations. Each applicant shall sign a statement acknowledging that the applicant has read and agrees to be bound by the Medical Staff Bylaws, Rules and Regulations

## **SECTION 8.6                      Appointment Process**

### **1. CLINICAL SERVICE CHIEF (CSC) RESPONSIBILITY**

- a. The CSC is responsible for recommending the initial appointment of all providers of clinical care on the CSC's service.
- b. Application for appointment shall be submitted to the COS's office by the CSC for review and to ensure all appropriate documents, certifications and signatures have been obtained and are in accordance with the Bylaws, Rules and Regulations and VHA regulations.
- c. If deemed appropriate by the COS, the CSC will arrange interviews of the applicant with the CSC, service members, other providers, the COS or designee, and where appropriate with representatives from UNM and the facility leadership.
- d. The CSC shall select an applicant to fill a vacant position based on review and evaluation of the credentials of all applicants, consultation with other individuals who have interviewed the applicants and consideration of the ability of the health care system to provide adequate facilities and support services.

### **2. CHIEF OF STAFF (COS) RESPONSIBILITY**

- a. Within 30 days or as soon thereafter as possible, when all necessary documents have been provided, the COS shall review the application and related documents and make recommendations to the CSC about interviewing the applicant.
- b. After a final decision is made to select a candidate for appointment to the Medical Staff, the candidate's name will be forwarded to the Medical Staff Office.

## **SECTION 8.7**

### **Appointment Action**

1. The appointment process shall be accomplished expeditiously:
  - a. For all applicants selected for appointment to the Medical Staff, the appropriate CSC in coordination with the Medical Staff Office shall promptly submit to the applicant's complete file (including application form, letters of recommendation, and curriculum vitae), with a recommendation to the COS for concurrence. The PSB shall evaluate the applicant's credentials, application for privileges, staff assignment(s) and recommendations of the CSC and recommend to the ECMS, their approval or disapproval of membership to the Medical Staff. Following concurrence by the ECMS, the COS shall promptly submit the recommendations to the HCSD along with the applicant's complete file for review and approval. Following receipt of the complete file, the Medical Staff Office shall, within 45 days, submit the file to Human Resources Management Service (HRMS) who shall advise the applicant as to the reporting date and procedures to follow in reporting for duty, and shall complete the appointment process.
  - b. HRMS will send letters of appointment to applicants after final approval by the HCSD.
  - c. A separate credentialing and privileging file for each Medical Staff member will be established and maintained. These files will be the responsibility of the COS and will contain documents relevant to credentialing and privileging. At any time the file is found to lack required documentation for any reason, efforts will be made to obtain the documentation. When it is not possible to verify required information all efforts will be documented in the credentialing and privileging file. This information is maintained in the Medical Staff Office.
  - d. Approved clinical privileges documents are placed in the individual practitioner's privileging folders. Copies are distributed to the practitioner and CSC.
  - e. Appointment requirements for administrative positions, e.g., CSC, COS, exceed the appointment requirements for other Medical Staff members. Physicians holding administrative positions must become members of the Medical Staff and must be credentialed, re-credentialed, privileged and re-privileged as appropriate

## **SECTION 8.8**

### **Term of Appointment and Continuation of Appointment**

1. The term of the initial appointment to the Medical Staff shall be governed by VHA regulations for employment. Continuation of that appointment to the Medical Staff shall be subject to demonstrated current competence. Reappraisal shall be completed at least every two years.

2. Personnel policies of the Department of Veterans Affairs for contract employment require that Consultant and Attending (C&A) staff be reappointed annually; however, their reappraisal/re-privileging needs to be completed only every two years and will follow a process similar to other appointments to the Medical Staff. Appointment and reappointment of the C&A staff shall be based on demonstrated current competence of the individual.

## **SECTION 8.9                      Provider Performance Evaluations**

1. Independent Entity: The NMVAHCS is an independent entity, granting privileges to the medical staff through the ECMS and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Mid-Level Practitioner, and Allied Health Professional reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff and Allied Health Professional must practice under their privileges or scope of practice.
2. Credentials Review: All Licensed Independent Practitioners (LIP), and all Mid-Level and Allied Health Professionals who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. All Mid-Level and Allied Health Professionals will be subjected to full credentials review at the time of initial appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a period not to exceed 2 years.
3. Deployment/Activation Status:
  - a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be placed in a "Deployment/Activation Status" and the credentialing file will remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Practitioner will update the credentialing file to current status.
  - b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the ECMS for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the CSC

and ECMS to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.

- c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.
  - d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care.
4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:
- a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.
  - b. Federal law authorizing VA to contract for health care services.
5. Initial Focused Professional Practice Evaluation:
- a. The initial focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege at the organization. A report of the initial FPPE must be made to the PSB 6 months after the EOD date or sooner if issues are identified. The report of initial FPPE may be postponed with approval of the COS, for example if an adequate number of records are not yet available for review and if no issues have been identified. A FPPE occurs with a new practitioner or an existing practitioner who requests a new privilege. The performance monitoring process is defined by each Service and must include;
    - (1) Criteria for conducting performance monitoring
    - (2) Method for establishing a monitoring plan specific to the requested privilege
    - (3) Method for determining the duration of the performance monitoring for a new privilege.
    - (4) Circumstances under which monitoring by an external source is required.
  - b. An initial Medical Staff appointment does not equate to HR employment. The initial FPPE does not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below;
    - (1) Initial and certain other appointments made under 38 U.S.C. 7401(I), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period,

professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations.

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

6. Ongoing Professional Practice Evaluation:

- a. The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the medical staff leadership. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.
  - (1) The timeframe for ongoing monitoring is quarterly. Consideration may be based not only on a period of time but also a specified number of procedures, and may consider high risk or high volume for an adjustment to the frequency.
  - (2) Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. Data that is not previously identified as protected by 38 U.S.C. 5705 and is collected as provider-specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program, and compared to pre-defined facility triggers or de-identified quality management data.
  - (3) In those instances where a practitioner does not meet established criteria, the service chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.
  - (4) The PSB and ECMS must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges. This deliberation must be clearly documented in the minutes.

- (5) The HCSD shall weigh all information available, as well as the recommendations of the PSB and ECMS, in the determination of whether or not to approve the renewal of privileges and document this consideration.
7. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a “for-cause” event requiring a focused review.
- a. A FPPE, implemented at time of initial appointment, will be based on the Practitioner’s previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, chart reviews, etc. and should be discussed with the Practitioner by the Service Chief.
  - b. A FPPE at the time of request for additional privileges will be for a period of time, a number of procedures, and/or chart review to be set by the Service Chief.
  - c. A FPPE initiated by a “for-cause” event will be set by the Service Chief. FPPE for cause ,where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges i.e., summary suspension
  - d. The FPPE monitoring process will clearly define and include the following:
    - (1) Criteria for conducting the FPPE.
    - (2) Method for monitoring for specifics of requested privilege.
    - (3) Statement of the “triggers” for which a “for-cause” FPPE is required.
    - (4) Measures necessary to resolve performance issues which will be consistently implemented.
  - e. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the Service’s policies and procedures.
  - f. If at any time the Service Chief or designee cannot determine the competence of the Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:
    - (1) Extension of FPPE review period
    - (2) Modification of FPPE criteria
    - (3) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner)
    - (4) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported )

## **ARTICLE IX**

## **CORRECTIVE ACTION, FAIR HEARING, AND APPELLATE REVIEW**

### **SECTION 9.1**

#### **Restrictions of Clinical Privileges**

1. All members of the Medical Staff shall be allowed to perform only those diagnostic or therapeutic procedures for which they are considered by their professional peers to be competent to perform. Clinical privileges shall be granted on the basis of the individual's training, experience, and demonstrated current competence, judgment and character.
2. The exercise of clinical privileges within any service shall be restricted by and subject to the rules and regulations of that service and the authority of the CSC, PSB and ECMS.

### **SECTION 9.2**

#### **Initial Determination of Clinical Privileges**

Every applicant requesting clinical privileges must complete the privileges form of the service assigned. The applicant shall have the burden of establishing qualifications and competency in the clinical privileges requested. The CSC shall review the applicant's credentials and requested privileges and submit them with their recommendations to the PSB for evaluation. Evaluation by the PSB of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information. The PSB shall recommend action of appropriate clinical privileges to the ECMS. The HCSD's approval of the requested privileges constitutes approval.

### **SECTION 9.3**

#### **Redetermination of Clinical Privileges**

1. Redetermination of clinical privileges is based on an overall reappraisal considering the following factors: current review of all licenses from all states and DEA registration review, NPDB query, a statement of current health status with affirmation by the CSC or COS, adequate continuing education activity (18 hours of CME for clinical psychologists, 25 CE hours for CNP/CNS, and 25 hours of Category I CME per calendar year or 100 hours of Category I CME within the last four years for all other members), the CSC's assessment and peer evaluations of care provided, peer review of the medical records of patients treated, findings of the medical staff committees which monitor the quality and appropriateness of patient care including

judgment and clinical or technical skills (results of quality management activities), timeliness of medical record completion and a review of patient care events which may have led to claims filed in the last two years. Based on the PSB's and ECMS's recommendations, the HCSD may approve or disapprove the renewal of clinical privileges within sixty days after receiving the request for renewal and before the lapse of the previous clinical privileges.

2. An effort will be made by the Medical Staff Office personnel to verify all credentials claimed. A good faith effort to verify is defined as a documented telephone call that includes date, time and by whom the call was made, and who was contacted, a copy of the registered letter sent or a copy of a fax sent.

#### **SECTION 9.4                      Changes in Delineated Clinical Privileges**

1. MODIFICATION, ENHANCEMENT OR EXPANSION - A staff member may request additional clinical privileges if the member believes such a change is warranted as a result of additional training, experience or change in circumstances. The process is initiated by submitting a new completed privileging request form with supporting documentation to the appropriate CSC. The procedures specified in these bylaws, where applicable, are then followed to obtain approval of the new clinical privileges.
2. REDUCTION OR TERMINATION - Privileges may be reduced or terminated if Medical Staff members make formal requests for such reductions or termination and give full explanations why such requests should be granted. Medical Staff members who fail to maintain the required degree of competency may have their clinical privileges reduced through actions of the COS and the HCSD. Emergency actions taken alone by the COS will be submitted for review to the PSB, ECMS and HCSD. It is the responsibility of the Institution, not the individual member of the medical staff, to make any reports to New Mexico licensing bodies (e.g., New Mexico Boards of Medicine, Nursing, Psychology, Dentistry, and Pharmacy) regarding changes in privileges or credentialing.

#### **SECTION 9.5                      Temporary, Expedited and Disaster Clinical Privileges**

1. Temporary appointment to the Medical Staff may be granted to a prospective medical staff member for a period not to exceed 120 working days. The temporary VA appointment is made under provisions of Title 38 or Hybrid Title 38. The temporary appointment to the Medical Staff may be approved by the HCSD upon recommendation of the applicable CSC (or designated alternate) through the COS



prior to receipt of all references or verification of other information and action by the PSB and ECMS. Verification of licensure, confirmation of possession of clinical privileges comparable to those to be granted, National Practitioner Data Bank (NPDB) query will be initiated, and a reference will be obtained prior to making such an appointment. Additionally, for physicians, Federation of State Medical Boards (FSMB) screening will be initiated prior to appointment, or if that is not possible, on the next administrative workday.

2. The PSB will review the action at the next regularly scheduled meeting. When there is no immediate urgency to the granting of temporary privileges, the applicant's signed acknowledgment of having read these Medical Staff Bylaws, Rules, and Regulations and agreement in writing to be bound by their terms in all matters relating to the temporary clinical privileges shall first be obtained before privileges are exercised. The recommendations of the CSC and COS shall be based on available information that reasonably supports a favorable determination regarding the qualifications, ability, and judgment of the applicant to exercise the privileges requested. If temporary clinical privileges are granted on the basis of general need rather than that of a specific patient situation, then there shall be designated supervision of the LIP who is granted temporary clinical privileges pending the processing of an application for an appointment to a longer term. Temporary privileges may be terminated at any time by the COS. Any such actions must be submitted to the PSB. In this event, the CSC (or alternate) shall assign responsibility for the care of such terminated practitioner's patient(s) to other appropriate member(s) of the Medical Staff. NOTE: Temporary appointments are for emergent patient care only and are not to be used for administrative convenience.
3. An expedited process may be used to grant clinical privileges when the usual process will result in delays in clinical care. The HCSD, upon the recommendation of the COS or Acting COS, may grant privileges prior to a meeting of the PSB when all conditions required for credentialing and privileging have been met. In all cases, when a practitioner has been granted expedited privileges a full presentation will be made at the next meeting of the professional standards board.
4. Disaster privileges may be granted when the emergency operations plan has been activated and NMVAHCS is unable to meet immediate patient clinical needs. The COS may grant privileges to a volunteer if a valid government-issued photo ID is presented and at least one of the following conditions are satisfied: a current picture hospital ID that identifies professional designation, a current license, primary source verification of the license or identification substantiating membership in a Disaster Medical Assistance Team or Medical Reserve Corps or Emergency

System for Advance Registration of Volunteer Health Professionals, prior granted authority to render patient care by a federal, state or municipal entity, or identification by a current medical staff member who possesses personal knowledge of the volunteer's ability to act as a licensed independent practitioner during a disaster. All volunteer staff will be assigned to a permanent member of the medical staff for oversight purposes. At the conclusion of 72 hours of service, performance will be reviewed and the COS will determine whether privileges shall be continued. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours or as soon as feasible from the time the volunteer LIP presents him or herself to the hospital. Volunteer LIPs will be identifiable with a Volunteer LIP badge assigned to that individual. Emergency privileges will be terminated when there is no further emergent or urgent patient care need.

## **SECTION 9.6                      Emergency Privileges**

When there is an emergent or urgent patient care need, a temporary appointment may be made, in accordance with Handbook 1100.19, by the facility Director prior to receipt of references or verification of other information and action by the Professional Standards Board. Evidence of current licensure verification, confirmation of possession of comparable clinical privileges and a reference will be obtained prior to making such an appointment. The facility Director must document, for the record, the specific patient care situation which warranted such an appointment.

## **SECTION 9.7                      Special Privileges Conditions for Dentists, Oral or Maxillofacial Surgeons and Podiatrists**

1. Patients admitted for oral or maxillofacial surgical, dental or podiatric care shall receive the same basic medical appraisal as patients receiving other services.
2. For podiatric patients, a podiatric member of the Medical Staff, designated member of the podiatric housestaff, or a physician member of the Medical Staff shall perform a history and physical examination. Consultation or co-management is initiated upon admission by a formal consultation to the appropriate service as defined in the service agreement.
3. For oral or maxillofacial surgery patients, an oral or maxillofacial surgery member of the Medical Staff or a physician member of the Medical Staff shall perform a history and physical examination. Consultation or co-management is initiated upon

admission by a formal consultation to the appropriate service as defined in the service agreement.

4. Surgical procedures performed by dentists, oral or maxillofacial surgeons or podiatrists in the operating room shall be under the overall supervision of the Chief, Surgical Service. Dental procedures performed outside of the operating room are under the overall supervision of the Chief, Dental Service.

#### **SECTION 9.8                      Privilege of Medical Staff in More Than One Service**

When privileges are normally exercised in more than one service, the chiefs of each of the involved services shall rule on the appropriateness of such privileges before the recommendations are forwarded.

#### **SECTION 9.9                      Uniformity of Privileging**

Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges, regardless of discipline or position. Practitioners shall be informed of privilege decisions within one month of approval by the HCSD.

#### **SECTION 9.10                    Denial of Medical Staff Appointments**

When review of credentials and recommendations contained in a complete application results in the denial of appointment, the COS will notify the applicant through the CSC that the appointment has not been recommended and will briefly state the basis for the action. The applicant may ask for a fair hearing of the denial. Such a request must be submitted in writing to the HCSD within five working days of receiving the denial of the request for appointment to the Medical Staff.

#### **SECTION 9.11                    Reduction, Revocation, and Suspension of Clinical Privileges**

1. The New Mexico VA Health Care System shall process reduction, revocation, and suspension of clinical privileges in accordance with the current edition of VHA Handbook 1100.19, Credentialing and Privileging.

2. The Director, Chief of Staff, Acting Chief of Staff or Chief of Service may detail or reassign temporarily a practitioner to non-patient care activities when not inconsistent with VHA Handbook 1100.19.
3. The Director may suspend clinical privileges for delinquencies of medical records and failure to meet other professional obligations when not inconsistent with VHA Handbook 1100.19.

## **SECTION 9.12                      Disclosure to the National Practitioner Data Bank and State Licensing Boards**

The New Mexico VA Health Care System shall report practitioners to the National Practitioner Data Bank and State Licensing Boards only in accordance with the current editions of *VHA Handbook 110.17, National Practitioner Data Bank Reports*, and *VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards*.

## **ARTICLE X                      GENERAL PROVISIONS**

### **SECTION 10.1                      Confidentiality and Release of Information**

1. Confidentiality of patient-specific and health provider-specific records and information shall be protected by, and information released strictly in accordance with, Federal laws, codes and VHA regulations.
2. Computer System Security – All Medical Staff will:
  - a. Effectively safeguard all assigned computer system passwords and codes (access/verify codes, electronic signature codes, etc.).
  - b. Consistently abide by established policies prohibiting the download of patient-specific data from the VA computer system to portable storage media such as diskettes, compact discs, zip discs, etc.; policies prohibiting employees from carrying any portable computer equipment or storage media containing any patient-specific data off VA premises; and policies prohibiting the loading of personal, non-VHA software, to any VHA computing equipment.
3. Confidentiality of Information – All Medical Staff will:
  - a. Consistently limit personal access to all sensitive information and records, including patient medical records, other patient-specific information, personnel

- records, and employee health medical records, to those instances in which there is a specific job-related purpose.
- b. Consistently maintain confidentiality of all sensitive patient and employee records and information, and limit disclosure of such information to only those individuals who have a specific job-related need to know the information.
  - c. Utilize software encryption as required on any laptop or personal computer as directed by VA IT Operations and Management.
4. Information Security Management - All Clinical Service Chiefs will:
- a. Assure that each subordinate is only allowed routine access to sensitive information to the extent necessary to perform the duties of the position.
  - b. Promptly inform appropriate management officials of any reported or personally observed suspected serious violations of computer security or information confidentiality.
  - c. Take appropriate measures to assure that subordinate employees comply with policies regarding computer security and confidentiality of sensitive information, and take appropriate disciplinary or performance-based action for employees found to have violated those policies.

## **SECTION 10.2                      Federal Tort Claims Act**

1. The Federal Tort Claims act provides for civil actions against the United States for money damages "...for injury or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee of the government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred". Excepted from this are claims arising out of certain torts such as assault, battery, false imprisonment, libel, slander and misrepresentation.
2. While the Federal Tort Claims Act (FTCA) provides a remedy against the Government, a type of statutory immunity from "individual" malpractice liability exists with respect to medical personnel of VHA; a person claiming "damages for personal injury, including death, allegedly arising from the malpractice or negligence of a physician, dentist, oral or maxillofacial surgeon, podiatrist, optometrist, clinical psychologist, nurse practitioner or clinical nurse specialists with privileges, allied health professional, physician assistant, expanded function dental auxiliary, pharmacist, or paramedical (for example, medical and dental technician, nursing assistant, and therapist) or other supporting personnel in furnishing medical care or treatment while in the exercise of such person's duties" has a possible remedy only

against the Government and not against the employee. Residents, interns, and "WOC employees," (e.g., medical students), may be included provided they are working under the direct supervision of VA healthcare professionals who are duly authorized to perform said function in NMVAHCS and provided the trainee's care was considered to be gross negligence, or willful professional misconduct.

3. In a situation in which the immunity statute would not apply, the immunity statute provides that the Secretary of the Department of Veterans Affairs may pay the judgment.
4. Medical Staff members have the responsibility to inform the COS of any legal actions brought against them for professional services performed outside NMVAHCS.
5. The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a Medical Staff member's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

## ***ARTICLE XI***                      ***REVIEW AND APPROVAL OF MEDICAL STAFF POLICIES***

### **SECTION 11.1**                      **Medical Center Memoranda (MCM)**

Medical Staff policies and procedures applicable to two or more clinical services or interfacing with administrative or allied health services shall be published as MCMs for distribution to all staff members, COS, and HCSD. MCMs are reviewed, revised as necessary, and updated at least every three years. They shall not conflict with each other, with the Medical Staff Bylaws, Rules and Regulations, or with VA regulations or policies.

### **SECTION 11.2**                      **Service Specific Policies and Procedures**

Medical Staff policies and procedures applicable to the functions of a particular clinical service shall be reviewed and revised as necessary.

## ARTICLE XII

## ADOPTION, AMENDMENT OR REVISION OF THE MEDICAL ***STAFF BYLAWS, RULES AND REGULATIONS***

### **SECTION 12.1**

#### **Approval, Adoption, Amendments and Repeals**

Approval and adoption of the Medical Staff Bylaws, Rules and Regulations shall occur upon recommendation of the active Medical Staff at any regular or special meeting of the Medical Staff at which a quorum is present and shall thereafter replace any previous Bylaws, Rules and Regulations. A simple majority vote of eligible members present at a Medical Staff meeting is necessary to approve, adopt, revise, amend or repeal the Bylaws, Rules and Regulations. They shall become effective when approved by the HCSD. Approval, adoption, amendments, repeals or revisions of the Bylaws, Rules and Regulations of the Medical Staff shall be approved by action of both, the Medical Staff, the ECMS and the HCSD. The Bylaws or Rules and Regulations may not be amended unilaterally.

### **SECTION 12.2**

#### **Review Interval**

The Bylaws, Rules and Regulations shall be reviewed by the ECMS at least every three years. Revisions will be entered to reflect the health care system's current policies with respect to Medical Staff organization and functions and shall be approved as provided under paragraph 17.1.

### **SECTION 12.3**

#### **Procedures for Amendment to Bylaws**

Proposed amendments to the Bylaws, Rules and Regulations may be submitted in writing to the COS by any service chief or member of the Medical Staff.

### **SECTION 12.4**

#### **Notification of Revision**

Proposed revisions or amendments to the Bylaws or Rules and Regulations shall be in writing circulated to members of the active medical staff or ECMS at least two weeks prior to any vote on any proposed changes.

## **SECTION 12.5**

### **Conflicts with VHA Regulations and Policies**

The Bylaws, Rules and Regulations, amendments, and revisions shall not conflict with VHA regulations; if such conflict is determined to exist, VHA regulations shall prevail until the Bylaws, Rules and Regulations can be brought into compliance. The Rules and Regulations of each service shall not conflict with the Medical Staff Bylaws, Rules and Regulations or VHA regulations.

## ***RULES AND REGULATIONS***

### **SECTION R.1**

#### **General**

1. The Rules and Regulations relate to the role and/or responsibility of members of the Medical Staff 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 and regulations of services will not conflict with each other, with the Bylaws, Rules and Regulations and policies of the Medical Staff or requirements of the Governing Body as expressed in policies of VHA or Federal Government.

### **SECTION R.2**

#### **Patient Rights**

The care, treatment and rehabilitation services will be modified to meet the patient's needs taking into account disease severity and disabilities. Patients and/or their family members and/or designated representatives have the right to:

1. Be given free access to information on patient's rights and be informed as to the process of handling patient complaints. Be informed about, the right of the patient or surrogate to consent to or refuse the recommended treatment and to be informed of the medical consequences of the patient's informed consent or refusal.
2. Be treated with dignity as an individual, with compassion and respect, reasonable protection from harm and appropriate privacy. Care should include consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness. Privacy is not solely privacy of the patient's body, but the privacy of disclosure of patient information. All verbal or written disclosures of facts regarding



a patient will be handled in accordance with VHA policies regarding the release of information;

3. Receive, to the extent the patient is eligible, prompt and appropriate treatment for physical or emotional disorders or disabilities, in the least restrictive environment necessary for treatment, free from unnecessary or excessive medication. In settings where a physician's history and physical exam is standard of care, this treatment will be under the medical direction of a licensed physician who is a member of the Medical Staff;
4. Communicate with those responsible for the patient's care and receive from them adequate information concerning the nature and extent of the clinical problem, the alternatives and recommended course of treatment and the prognosis; be informed as to the nature and purpose of any medical treatment or technical procedures performed on the patient, as well as to know why and by whom such medical treatment and/or such recommended procedures are to be carried out; to know the identity of the physician primarily responsible for the patient's care; and to expect adequate instruction in self-care in the interim between visits to NMVAHCS or to the physician;
5. Participate in decisions of an ethical nature and receive information and assistance in formulating advance directives and in the appointment of a surrogate to make health care decisions for them;
6. Receive information about adverse events that materially affect the patient's care;
7. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of this action;
8. Receive any information regarding human experimentation or research or education projects affecting the patient's health care, and to refuse to participate in experimental or research protocols, without jeopardizing care.

### **SECTION R.3                      Informed Consent**

1. It is NMVAHCS policy that patients may accept or refuse treatment offered to them. Electronic/written consent is required before any major treatments or procedures are initiated. The patient must be clearly informed regarding the nature of the procedure or treatment to be undertaken, the risks and benefits of the treatment, alternatives to consider and the expected outcome if the treatment is declined or accepted.

NMVAHCS informed consent policies and procedures will conform to VHA Handbook 1004.01

2. Documentation of the informed consent and the informed consent discussion must be made in the medical record with all the considerations described in the most current MCM 11-21 on informed consent.

## **SECTION R.4                      General Responsibility for Care**

### **1. CONDUCT OF CARE**

- a. The management of the patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff.
- b. The same quality of patient care will be provided by all individuals with delineated clinical privileges within and across all services of this health care system and between all staff members who have clinical privileges.

### **2. EMERGENCY MEDICAL SERVICES**

- a. Emergency services will be guided by facility policies, procedures and guidelines in compliance with EMTALA.
- b. Evaluation of patient applicants requesting emergency care will be according to need as defined by a medical center defined triage protocol. Those with emergent or urgent conditions will be treated regardless of legal eligibility for care in a VA facility.
- c. Patients without emergent or urgent care needs who are not legally eligible for care will be referred to appropriate facilities.

### **3. ADMISSIONS**

- a. Only members of the Medical Staff with admitting privileges will be permitted to admit patients. Housestaff admit patients under supervision of the Medical Staff.

## **SECTION R.5**

### **Professional Education**

1. Medical Staff members shall participate in a program of continuing medical education designed to keep them informed of significant new developments in medicine.
2. Medical Staff education will include health care system based programs, planned and scheduled in advance and held on a continuing basis and educational opportunities held within or outside the health care system sponsored by educational institutions, societies or organizations approved for Continuing Medical Education (CME).
3. Documentation of these activities will be kept in order to evaluate scope, effectiveness, attendance and the amount of time at such effort.
4. This continuing education must be documented in the Medical Staff member's file. Departmental meetings at which continuing education is conducted may be used, but they must be documented and approved for appropriate CME credit

## **SECTION R.6**

### **Supervision**

1. Members of the Medical Staff, housestaff, Allied Health Professionals, and medical students participating in the care of patients shall make appropriate entries in the medical records consistent with their delineated privileges, licensure limitations, and health care system policy. The Medical Staff member primarily responsible for the patient shall document supervision of care provided by housestaff, allied health professionals and medical students in progress notes in the medical record as frequently as deemed clinically appropriate.
2. Entries in the medical record requiring countersignature by Medical Staff or the supervising resident are listed below by category of personnel making the entry:
  - a. All orders placed in the medical record by medical, dental, optometric, and podiatry students shall be signed by a credentialed and privileged staff practitioner who possesses a valid state license to practice medicine.
  - b. Prior to high-risk interventions, the patient histories and physical exams written by PAs or APRNs shall be amended as necessary and countersigned by a licensed physician.

- c. Entries made in the medical record by students cannot be accepted in lieu of required entries by residents or medical staff members.
- 3. The medical record must document that a member of the Medical Staff has seen the patient and concurs with the diagnosis and treatment plan. The staff member must also demonstrate continued supervision of the resident, APRN (CNS, NP, CRNA), or PA by appropriate documentation on the chart as required by VHA Directive.
- 4. The Medical Staff member responsible for the patient's care shall document supervision of care and treatment provided to patients by members of the housestaff and allied health professionals in progress notes of the patient's medical record as designated by the current version of VHA Resident Supervision Handbook.
- 5. Student Trainees may be permitted to perform minor surgical and medical procedures, under the direct supervision of a staff practitioner of the medical staff privileged to perform the procedure.
- 6. Adverse events identified from peer review, tort claims or compliance reviews where the findings reveal a lack of supervision of residents or allied health providers must be forwarded by Quality Management to the COS or Acting COS. If the COS or Acting COS agrees that inadequate supervision was a contributing factor, then the case will be forwarded to the CSC of the Medical Staff member who was responsible for the patient. When the case involves inadequate supervision of a resident, the COS or Acting COS will also notify the ACOS for Education & Academic Affiliations and the CSC will notify the VA residency program director.

## **SECTION R.7                      Admissions, Discharges and Patient Care**

- 1. NMVAHCS can accept only those patients for care and treatment who are medically and legally eligible as defined by current law and policies of VHA and NMVAHCS. For humanitarian reasons, in the case of a true medical emergency, medical care shall be rendered to a non-eligible patient until such time as the patient's condition is stabilized to the degree the patient can be either transferred to another health care facility or sent home.
- 2. Admission to a setting where a staff practitioners admission history and physical exam is standard of care is restricted to appropriate housestaff or licensed physicians (MDs, Dos, Podiatrists, or Maxillofacial Surgeons), who are appointed to

attend patients. Patients may be denied admission only by professionals who have the above described admitting responsibilities.

3. Except in an emergency, no patient shall be admitted until after a provisional diagnosis has been stated on the medical record. Medical Staff members will examine and make the proper disposition of all eligible patients.
4. Final authority for admission and assignment to a service rests with the admitting medical professional.
5. Upon admission to inpatient care at NMVAHCS, each patient shall be assigned to the clinical service or section deemed most appropriate for the care and treatment of the condition for which hospitalization is required.
6. In acute care settings, a history and physical examination and initial plan of care shall be entered and signed, and co-signed when required, and accompanied by an independent assessment by the responsible medical staff member within 24 hours of admission. For residential settings (SA-, DR-, and PR RTP), completion must occur within seven days of admission. For long-term care settings such as the CLC completion must occur within 72 hours after admission. If the most recent H&P is less than 30 days old, then a new history and physical need not be conducted but an interval addendum must be completed that details any changes in medical history or physical examination.
7. TRANSFER OF PATIENTS
  - a. Patients shall not be transferred from one bed service to another or out of an ICU or PACU without a signed order by a Medical Staff member or a housestaff physician.
  - b. Transfers from one bed service to another will be accomplished only by mutual agreement of the bed services involved.
  - c. There must be a transfer summary entered by the transferring Medical Staff Member or housestaff. It will be a concise recapitulation of the hospital course to date to assist the receiving staff practitioner who assumes responsibility for the continuity of inpatient care. The receiving staff physician must enter a note of acceptance that includes a plan of care.
  - d. All orders will automatically be discontinued on moving from one service to another or when the patient goes to the operating room.
  - e. A ward clerk or a nurse will be responsible for promptly notifying a receiving staff practitioner as soon as a new patient has arrived on the ward.

8. Each patient shall be the responsibility of a member of the Medical Staff. Such Medical Staff member shall be responsible for medical care and treatment, for the prompt completion and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring Medical Staff member and for communicating to relatives of the patient, as indicated. Although the day-by-day treatment of the patient, which includes entering patient care orders, may be delegated to the housestaff, the responsibility for patient care rests with the Medical Staff member. Whenever these responsibilities are transferred to another staff member or service or to another health care facility, an order covering the transfer shall be entered in the medical record.

## 9. DISCHARGE OF PATIENTS

- a. Patients shall be discharged only on the order of a member of the Medical Staff with admitting privileges or by housestaff under the direct supervision of a member of the Medical Staff with clinical privileges. No discharge will be effected without adequate provisions for continued follow-up care. A progress note documenting the condition of the patient and readiness for discharge shall be entered into the medical record on the day of discharge.
- b. Patients shall be provided all medically necessary medications, equipment and supplies upon discharge or arrangements shall be made to provide these as soon as possible after discharge. All medically necessary follow-up care shall be arranged and these arrangements shall be communicated to the patient and entered into the medical record at the time of departure or as soon as possible after discharge.
- c. An updated list of medications, the dose prescribed and the total quantity prescribed, shall be entered in the medical record and provided to the patient. The discharge medications shall be given to the patient or a responsible adult with instructions on how the medicine is to be taken and what the possible side effects might be.
- d. Plans should be made to discharge patients before 11:00 a.m., if possible.
- e. Should a patient leave against the medical advice (AMA) of the attending staff practitioner or house-officer or without following the proper discharge procedures, notation of this incident and discussion regarding the risks of discharge shall be made in the patient's medical record. When possible, patients shall sign an acknowledgement that discharge is against medical advice. Patients may refuse to sign the acknowledgement and this should be documented. The appropriate staff shall be notified promptly for completion of administrative details.

## **SECTION R.8**

### **Patient Orders**

1. All medical orders for patient care must be entered in the medical record and signed by members of the Medical Staff, housestaff or a provider authorized to enter orders by functional statement or scope of practice. Handwritten orders (only used during computer downtime), must be legible, dated and signed by members of the Medical Staff, physician housestaff or authorized provider issuing the order, before the instructions are executed.
2. All orders for medications, diagnostic tests or procedures must be placed by an authorized ordering practitioner. An ordering practitioner is a practitioner authorized to enter and sign orders by privileges or scope of clinical practice. All orders for treatment shall be signed by a member of the Medical Staff or housestaff or by other individuals within the authority of their clinical privileges or specified duties.
3. It is ideal if all orders are entered by providers into the medical record. However, verbal or telephone orders shall be acceptable in situations when telephonic or verbal orders are the most practical and expeditious means of continuing the patient's care. Verbal or telephone orders must be given by a provider with prescribing authority directly to an authorized recipient such as a pharmacist or nurse who will immediately transcribe the order then read back the order to confirm the content with the provider. Verbal or telephone orders should be signed by a provider by the next business day following the order.
4. Orders which are not understandable as entered will not be carried out until clarified by the author.
5. **MEDICATION ORDERS**
  - a. With few exceptions, inpatient medication orders will automatically expire in 28 days. Automatic stop order exceptions will conform to Pharmacy Service MCMs. The Medical Staff Member, Housestaff Member or Allied Health Provider with prescription privileges will be notified prior to the expiration date via a view alert.
  - b. Drugs used shall meet the standards of the United States Pharmacopoeia, National VA Formulary, New and Non-Official Drugs, with the exception of drugs for clinical investigation. Investigational drugs may be used only on research protocols which have been approved by the Institutional Review Board and the Research and Development Committee.
  - c. Automatic stop orders shall be adhered to in accordance with current medical center policy. An automatic stop order does not apply when the number of doses in an exact period of time is specified.

- d. Patients are discouraged from bringing medications into the health care system. If a patient or his caregiver brings medications into the HCS and is unable to take the medications home, the patient or caregiver will be advised that any medications left at the HCS will be sent to pharmacy and destroyed per Pharmacy Service MCM.
- e. Self-administration of drugs by patients is not allowed except in specific units identified in the most recent NMVAHCS Medication Self-Administration Policy when specifically ordered by the responsible medical professional. It is reserved for patients who have been deemed competent in self-administration and for whom self-administration of drugs is important for their overall medical care.

## **SECTION R.9                      General Rules Regarding Surgical Care**

1. Every attempt should be made to perform operations on an outpatient or if not possible, on a day-of-surgery admission basis.
2. The history and physical examination shall be recorded prior to the time stated for a surgical procedure. If they are not, the surgery shall be delayed to allow time to complete this documentation unless the surgeon states in writing in the medical record that such delay would constitute a hazard to the patient. Outpatient surgery requires an H&P that is less than 30 days old. This H&P must be written in enough detail to allow the formulation of a reasonable picture of the patient's clinical status. This includes sufficient information from the patient's history and the surgeon's exam to document why surgery is appropriate. A brief assessment and plan are also essential. If the most recent H&P is less than 30 days old, then a new history and physical need not be conducted but an interval addendum must be completed (within 24 hours prior to admission but always prior to surgery or any procedure that requires anesthesia services) that indicates any changes in medical history or physical examination and medications. If the indications for surgery have changed, a statement describing these changes must also be included in this addendum to the initial H&P.
3. Major surgical operations and other invasive procedures other than emergency procedures, shall not be performed until adequate clinical data, which may include radiology and laboratory results, are recorded on the chart.
4. Surgical operations and other invasive diagnostic and therapeutic procedures shall be undertaken only with the prior, informed, voluntary consent of the patient or where appropriate through the patient's legal representative. The electronic/written



informed consent shall be in the medical record before the surgical procedure begins.

5. Electronic/written, signed, informed surgical consent shall be obtained within 60 days prior to an operative procedure by the responsible staff professional except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving an unconscious patient when consent for surgery cannot be immediately obtained from next of kin, these circumstances should be fully explained in the patient's medical record by the operating staff surgeon. The service chief or designee must be consulted for concurrence. VA forms will be used and the name of the operating surgeon and the second (consulted) medical staff member will be on the consent form.
6. In accordance with VHA Handbook 1106.1, all tissue, foreign bodies, and other specimens removed from patients are to be referred to the Pathology and Laboratory Medicine Service for examination or disposition as is necessary to arrive at a pathological diagnosis, unless specifically exempted by the clinical governing body of the facility as defined by MCM 113-2 Pathologic Examination of Patient Specimens. Other tissues, not described in MCM 113-2, shall be sent to Pathology at the discretion of the surgeon. Specimens shall be adequately labeled as to patient's name, full social security number and tissue source and shall be accompanied by a tissue examination form with pertinent identification and clinical information. An electronically signed report will be placed into the medical record to document the pathologic diagnosis. All tissue shall remain the property of the health care system under the custody of the Chief, Pathology and Laboratory Medicine Service.
7. There must be evidence in the medical record of a pre-anesthesia visit. For all in-patients a post-anesthesia visit and documentation shall be made within 48 hours after the procedure.
8. The release of every patient from the post-anesthesia recovery unit shall be in accordance with the recovery room policy.
9. Operative reports must be dictated or entered in the medical record immediately after surgery. They should contain a description of the findings, technical procedures used, specimens removed, pre-operative diagnosis, post-operative diagnosis, type of anesthesia, estimated blood loss and name of the primary

surgeon and any assistants. This must also include indication and description of the procedure. A brief operative note must be entered into the medical record immediately following the surgical procedure and prior to transfer and/or discharge from the PACU or ASU.

10. Prior to the start of surgical operations and other invasive procedures a final verification process (time out) will be performed to confirm the correct patient, procedure and site, availability of pertinent radiologic studies and implants.

## **SECTION R.10                      Special Treatment Services**

1. Treatment procedures that require special justification:
  - a. The Medical staff member and housestaff must comply fully with the physical restraint and/or seclusion policy MCM 11-78 for that specific patient care setting;
  - b. Electroconvulsive therapy is not performed on children or adolescents in this facility;
  - c. Psychosurgery is not performed in this facility;
  - d. Behavior modification procedures that use aversive conditioning are not done in this facility;

## **SECTION R.11                      Consultations**

1. The Medical Staff through its CSCs shall assure that appropriate consultations will be requested. Any member of the Medical Staff may be requested to provide consultation within the Medical Staff member's area of expertise. Consultation is urged for the following situations:
  - a. When the patient is not a good risk for an operative or invasive procedure;
  - b. Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed;
  - c. Where there are significant differences of opinion as to the best choice of therapy;
  - d. In unusually complicated situations where specific skills of other practitioners may be helpful;
  - e. When specifically requested by the patient or their family and with concurrence by the staff practitioner;
  - f. For all patients who have attempted suicide or who have had self-administered medication overdoses, psychiatric consultation will be provided;

2. Each consultation report shall be a part of the medical record and should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and review of the patient's medical record;
3. A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical Staff on the basis of the individual's training, experience and competency. Residents or Fellows may act as consultants. All consultation notes should document the involvement of the appropriate medical staff member on the consulting service;
4. A satisfactory consultation includes an interview and examination of the patient and review of the medical record. When operative and other invasive procedures are involved, the results of the consultation, except in an emergency, shall be reported prior to the procedure;
5. The CSCs will make certain that members of their staff provide timely consultation as needed;
6. Consultation may be initiated by a medical staff member, by the housestaff or a provider authorized to initiate consultations by functional statement, scope of practice or medical center policy. Other health care providers may request a consultation by a staff practitioner only after obtaining approval from a member of the medical staff and must submit the request in the approving medical staff member's name. The consultation request should be in electronic format or in writing on the appropriate form and addressed to the specific service or person. Consultation requests should clearly set forth the problem and provide information requested and meet Service Agreement pre-requisites if required.
7. Consultation should be requested for valid medical or educational reasons;
8. Responding to consultation requests.
  - a. The responsibility of determining policy regarding answering of consultation requests rests with the CSCs and/or subspecialty section chief. Any consultation shall be provided with a high level of professional competency, efficiency and promptness both for service to the patient and for educational purposes. Fellows or residents may respond to consultation requests but final responsibility for the consultation resides with the medical staff member. The person actually examining and writing the consultation advice should sign the consult note. When this is not a member of the medical staff, a medical staff member must

indicate his/her agreement with the opinion by co-signature and a comment added to the consultation. All consultation notes should document the level of involvement of the appropriate staff person and meet supervisory requirements as set by the Office of Academic Affiliations.

9. Consultants should exercise appropriate clinical judgment when informing patients of their findings and opinions in accordance with the ethical principles governing the consultation process including full and timely communication of the results to clinicians involved in the patient's care;
10. If a health care professional has any reason to doubt or question the quality of care provided to any patient and feels that appropriate consultation is needed and has not been obtained, the health care professional shall direct said question(s) to the attending Medical Staff member. If after this, the health care professional still feels their question(s) has not been resolved, the matter should be called to the attention of a CSC who will attempt to solve the problem through appropriate channels including ethics consultation service. If not resolved, final disposition of such concerns shall be made by the COS or Acting COS;

## **SECTION R.12                      Medical Records**

1. Members of the Medical Staff or housestaff who have admitted a patient or evaluated a new patient in the outpatient setting must record sufficient information in the medical record to identify the patient, to support the diagnosis and to justify the treatment and a plan of care. Minimum elements for a history and physical include a chief complaint, history of present illness, pertinent medical, surgical, psychiatric, family and social history, pertinent review of systems, pertinent physical and mental status examination, and an assessment of problems and a plan of care;
2. Records will be created and maintained electronically or typed into the Consolidated Patient Health Record System (CPRS) following the format approved by Veterans Health Administration or as modified at NMVAHCS, after approval by the Medical Records Review Committee (MRRC). Handwritten documentation will be used only during documented outages of CPRS;
3. Each consultation report shall be entered into CPRS (or scanned into CPRS when electronic entry is not feasible) and contain an opinion by the consultant that reflects, where appropriate, an actual examination of the patient and review of the patient's medical record and the opinion of the consultant;

4. Progress notes shall be written by the Medical Staff Member or housestaff as designated by the current version of VHA Resident Supervision Handbook. Documentation using established criteria of attending supervision of housestaff must be included in every record. Progress notes shall be written by housestaff as frequently as is designated by the current version of VHA Resident Supervision Handbook. All entries shall be dated and authenticated;
5. Progress notes shall give a pertinent chronological report of the patient's course in the health care system and should reflect any change in condition that results in a change of treatment or diagnostic procedure plans. They shall be complete; they must be dated and, when appropriate, they should be timed. They shall be recorded at a frequency appropriate to the condition of the patient: no less than daily in acute care settings, no less than daily for the first 30 days of admission to the SCI Ward, thereafter as frequently as indicated by patient condition, but no less than three times per week for an SCI patient with a stable, chronic condition, and for each outpatient visit, telephone or electronic encounter (email, video or other means of electronic communication). Notes accompanying any patient encounter shall be signed on the day the encounter occurred or by close of the next business day when mitigating circumstances are present;
6. Reports of procedures, tests, and results shall be documented in the medical record and evidence that such information was used in determining patient care is required;
7. The attending Medical Staff member or housestaff shall write into the medical record of each patient as soon after admission as possible the following:
  - a. The provisional diagnosis or recognized clinical problems;
  - b. An initial note stating the cause of hospitalization, the clinical findings, and the course of treatment contemplated;
  - c. Each clinical event shall be fully documented as soon as possible after its occurrence. A history and physical examination shall be completed within 24 hours after admission in all settings where a staff practitioner's admitting history and physical exam is a standard of care;
8. Symbols and abbreviations may be used only as allowed in the most recent local policy on the use of abbreviations in the medical record;
9. The latest editions of Current Medical Information and Terminology, the Current Procedural Terminology of the American Medical Association and the Diagnostic

and Statistical Manual of Mental Disorders of the American Psychiatric Association shall be used to provide uniform disease and operation terminology;

10. Laboratory, radiology, EKG, pathology and other essential reports must be incorporated into the medical record within 24 hours of completion of the diagnostic test;
11. Medical records will be completed insofar as possible at the time of discharge including signature, discharge note, diagnosis, operations and/or procedures. A complete and signed discharge summary and discharge instruction must be available in CPRS prior to discharge.
12. After discharge, the medical record will be assembled in proper order by the ward clerk and sent to medical records. In the event of death, a summation statement or a final progress note indicating the reason for admission, the course in the hospital, and the events leading to death should be recorded in the patient's chart immediately;
13. A Discharge Summary shall be prepared at each termination of hospitalization. It must include the final diagnosis, operations or procedures performed and a concise recapitulation of the reason for admission, significant findings, and treatment rendered. It should also include the condition of the patient at discharge, the patient's medical problems, recommendations for and location of follow-up care, medications given, and all instructions provided to the patient and/or family (including diet, activities, and follow up appointments). An updated list of medications, the dose prescribed and the total quantity prescribed, shall be entered in the medical record and provided to the patient. The discharge medications shall be given to the patient or a responsible adult with instructions on how the medicine is to be taken and what the possible side effects might be. Other instructions will be given in writing at the time of discharge.
14. For settings where a staff practitioner's admitting history and physical is required, a physician member of the staff shall be responsible for the completed medical record for each patient. The medical record should include: identifying data (including age and gender); chief complaint, history of present illness, pertinent medical, surgical, family and social history, pertinent review of systems, pertinent physical examination, provisional diagnosis; current medications, a clear indication for all medications ordered, allergy information, all diagnostic laboratory and radiological tests; medical treatments or procedures; surgical or invasive procedures, preoperative diagnosis, operative reports, and pathological findings; special reports

such as consultations; progress notes including condition on discharge (discharge note) and final diagnosis; final summary at discharge, discharge instructions, follow-up and preliminary results of the autopsy when performed;

15. No medical record shall be closed until it is complete, except upon the recommendation of the Chairperson, MRC using established criteria;
16. All new patients or patients readmitted thirty or more days following discharge from the prior admission shall have a history and physical examination unless being admitted to a setting that does not require an admission history and physical examination;
17. Patients who are re-admitted within 30 days shall have at a minimum, a review of the prior testing and physical examination, a note documenting such review and updates of any history, physical findings and a new assessment and plan of care;
18. Final diagnoses, operations, or procedures must be written using terminology consistent with the latest directives from VA Central Office;
19. Necropsy reports should be made part of the patient's medical record within timelines to those outlined in facility MCMs;
20. A contemporaneous progress note will be completed for each episode of outpatient care with review and signature within 3 working days of its entry into the record;
21. A medical record is determined to be complete when all required contents are assembled and authenticated as previously outlined. All summaries are to be signed by the attending Medical staff member. A medical record, which remains incomplete more than 30 calendar days following discharge, is considered a delinquent record;
22. All entries in the medical record shall be entered electronically by dictation or typed by the clinical provider and identified by signature and title;
23. Signature stamps may be used only in conjunction with the personal signature or initial for legibility in the medical record;
24. Access to all medical records of all patients shall be afforded to staff members for bona fide study and research while preserving confidentiality in accordance with the privacy Act of 1974 and the federal laws on alcohol, drug abuse, sickle cell, and HIV;

25. All records are the property of NMVAHCS, and can be removed from the premises only under court order, statute, subpoena or conditions consistent with VA regulations such as designated contracting officials;
26. Staff members, who are chronically delinquent and fail to complete their assignments, including records, may be subject to disciplinary actions. Furthermore, such negligence may become part of their re-privileging information;
27. Appropriate documentation in the medical record includes information required for third party billing and must be made in accordance with the considerations described in the most current Health Care System Memorandum on Provider Responsibility for Documentation;

#### **SECTION R.13                      Quality of Professional Services**

1. Ambulatory Care services shall meet the same standards of quality as those that apply to inpatient care, given the inherent differences between inpatients and outpatients with respect to their needs and modes of treatment.
2. The quality of care provided in the outpatient service will be measured as part of the Health Care System's Quality Management Program.
3. Evaluation of the efficiency and effectiveness of ancillary patient services shall be carried out systematically in an objective manner and appropriately documented. Overall responsibility for the quality of medical care rests with the Medical Staff.
4. The quality of patient care shall be evaluated by members of the Medical Staff and other members of the professional staff directly responsible for patient care.
5. Evidence of the quality of patient care provided in the health care system shall be demonstrated by measurement of actual care against specific criteria. These criteria must be established or adapted by the Medical Staff for evaluation of all physician-directed care and by non-physician health care professionals for evaluation of those aspects of patient care that they provide.
6. Criteria must be explicit and measurable and must reflect the optimal level of care that can be achieved through current medical and related health science knowledge.



7. Quality of care reviews should include expected patient outcomes of the result of intervention by physicians and other health care professionals.
8. If review indicates an inappropriate pattern of patient care, action must be taken to correct the problem. Such actions must be specific to the problem and may include education or training programs, amended policies or procedures, increased or realigned staffing, provision of new equipment or facilities or adjustments in staffing privileges.
9. To demonstrate that corrective action has been effective, follow-up studies must be conducted.
10. Patient care activity must be evaluated and its results reported to the CEB. The evaluation activity shall be continuous and shall be comprehensive of conditions and problems treated and procedures performed. The results of quality of care evaluations shall be specifically reflected in other quality protective functions of the Medical Staff, including appointment and reprivileging of Medical Staff members. Control of the utilization of NMVAHCS resources, the continual monitoring of practice within the professional staff, and the provision of continuing professional education is the responsibility of the Medical Staff in cooperation with the health care system management.

#### **SECTION R.14                      Handling of Autopsies**

1. In the interest of improving patient care and professional knowledge, every member of the professional staff is expected to participate in securing autopsies on all deaths. No autopsy shall be performed without consent of the patient's next of kin or legally authorized agent. In every case of death in the health care system the Medical Staff member or housestaff member should contact the patient's next of kin or legal agent and request permission to perform an autopsy and then document the response in the medical record.
2. Consent for autopsies will be obtained by signature of the next of kin on the appropriate form, including any limitation imposed by the next of kin. Permission for donation of any organ or tissue would be included. The physician staff will provide information regarding clinical diagnosis and concerns to the pathology staff prior to the autopsy, specifically including any infection hazards.
3. Autopsy examinations are strongly encouraged in the following deaths:

- a. Deaths in which an autopsy may help to explain unknown and unanticipated medical complications or deaths in which the cause is not known with certainty on clinical grounds;
  - b. Cases in which an autopsy may help allay concerns of the family and provide reassurance to them;
  - c. Unexpected and unexplained deaths occurring during or following any dental, medical, surgical, diagnostic and/or therapeutic procedures;
    - (1) Deaths of patients who have participated in clinical trials approved by the institutional review board;
    - (2) Deaths known or suspected to have resulted from environmental or occupational hazards;
    - (3) Deaths in which it is believed that the autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs;
    - (4) Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction;
4. Deaths that are subject to the Office of the Medical Investigator (OMI) jurisdiction. Cases in which the OMI must be notified at the time of death are:
- a. Persons dead on arrival at NMVAHCS;
  - b. Deaths occurring in NMVAHCS within 24 hours of admission;
  - c. Deaths in which the patient sustained or apparently sustained an injury while hospitalized that might have contributed to the patient's demise;
5. Family members or legal guardians may request copies of the autopsy examination. The Office of Release of Information will handle such requests;
6. Results of autopsy findings will be documented in the electronic medical record according to timelines established by MCM 113-3 Autopsy Policy;
7. As part of the Quality Management Program, a copy of the autopsy results will be sent to the treating service. Findings from autopsies may be used as a source of clinical information in seeking to continually improve patient care at NMVAHCS;

## **SECTION R.15**

### **Disaster Plan**

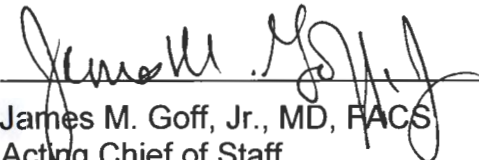
Mass casualty assignments for staff practitioner may require assignment to posts with the health care system or at auxiliary facilities or to mobile casualty stations. It is the

physician's responsibility to report to the assigned station when needed. The COS, Acting COS and HCSD or designee will coordinate activities and direction. In cases of evacuation of patients from one section of the health care system to another or evacuation from health care system premises, the COS or Acting COS, will authorize the movement of patients as directed by the HCSD or designee. All policies concerning patient care will be the responsibility of the COS or HCSD or designee.

## **SECTION R.16                      Conflicting Rules and Regulations**

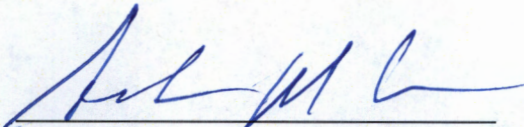
These Rules and Regulations are further specified in MCM and VA regulations. The rules and regulations of each service shall not conflict with each other, with the Bylaws, Rules and Regulations of the Medical Staff, or with VHA and health care system policy.

ADOPTED BY THE MEDICAL STAFF OF THE  
NEW MEXICO VA HEALTH CARE SYSTEM  
Albuquerque, New Mexico 87108

  
James M. Goff, Jr., MD, FACS  
Acting Chief of Staff  
Chair, Clinical Executive Board

DATE: 4/7/2015

APPROVED BY THE HEALTH CARE SYSTEM DIRECTOR

  
Andrew M. Welch, MHA, FACHE  
Director

DATE: 4-10-15