BYLAWS AND RULES OF THE MEDICAL STAFF

South Texas Veterans Health Care System

Department of Veterans Affairs

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INDEX

MEDICAL STAFF BYLAWS AND RULES

PREAMBLE

The South Texas Veterans Health Care System (STVHCS) is an integrated system organized to provide comprehensive health care services to eligible veterans in South Texas. STVHCS has two major facilities, the Audie L. Murphy Acute Care Facility in San Antonio and a general medical and long term care facility in Kerrville. STVHCS has smaller facilities to serve outpatients through satellite clinics. STVHCS is part of the Veterans Health Administration (VHA) headquartered in Washington, D.C. STVHCS is affiliated with the University of Texas Health Science Center San Antonio.

There is a single, self-governing, Organized Medical Staff that provides oversight for a uniform quality of patient care, treatment and services provided by practitioners who are credentialed and privileged through the Medical Staff process. The Organized Medical Staff is responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners, and providing leadership in performance improvement activities within the organization. The Medical Staff reports to and is accountable to the governing body. The Secretary of Veterans Affairs and the Under Secretary for the Veterans Health Administration (VHA) have delegated governing body status to the Director of the area Veterans Integrated Service Network (VISN 17) with the Director of STVHCS serving as the local governing body.

These Bylaws initiated and developed by the Organized Medical Staff describe the organizational structure of the Medical Staff, the rules for self-governance, and the accountability to the governing body. The Medical Staff shall enforce and comply with these Bylaws. The governing body approves and complies with the Medical Staff Bylaws. Neither the Organized Medical Staff nor the Director shall unilaterally modify these Bylaws.

All members of the Medical Staff are subject to these Bylaws and all applicable STVHCS and VHA policies, procedures, and federal law and regulations. All applicants applying for clinical privileges must be provided with a copy of the Medical Staff Bylaws and Rules and must agree in writing to accept the professional obligations reflected therein. All renewal applicants must attest to the Medical Staff Bylaws and Rules through the Vetpro Credentialing Program. Members of the Medical Staff must be notified in writing and/or provided a copy of, or have ready access to, the revised text when significant changes are made in these Bylaws and Rules.

STVHCS policies and procedures specific to the Medical Staff (e.g., STVHCS Policy Memoranda) which serve as the rules and regulations of the Medical Staff (as referenced in the rules) must be recommended by the STVHCS Clinical Executive Board (CEB) and approved by the governing body (Director). Neither the CEB nor the Director shall unilaterally modify these policies and procedures applicable to the Medical Staff. These Bylaws, Rules and regulations, and policies of the Medical Staff and the Governing Body Bylaws (e.g. policies, Handbooks, Directives, and Manuals) must not conflict. These Bylaws do not create any rights or liabilities not otherwise provided for in VHA regulations or Federal law and regulations. There must be medical staff representation and participation in any STVHCS deliberations that affect the discharge of medical staff responsibilities.

The Medical Staff shall adhere to applicable VHA regulations and Joint Commission standards in matters that are not specifically addressed in these Bylaws and policies and procedures applicable to them.

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff and committees to which they have been assigned. A member of the Medical Staff is obligated to attend any meeting with the Chief of Staff, Director, CEB, or other medical staff committee to which they are specifically invited

DEFINITIONS:

1. AFFILIATE. The University of Texas Health Science Center at San Antonio is the affiliate entity that holds the Graduate Medical Education Program certification.

2. APPOINTMENT. The term "appointment" refers to the Medical Staff. It does not refer to appointment as a Department of Veterans Affairs (VA) employee (unless clearly specified), but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority for providing patient care services at the facility. Both VA employees and contractors may receive appointments to the Medical Staff.

3. ELECTRONIC MEDICAL RECORD (EMR): Computerized Patient Record System (CPRS) is the primary patient record system that stores information in VistA, or other automated systems using electronic storage. CPRS supports entry of notes and orders, rules-based order checking, and results reporting. Also integrated into CPRS is VistA imaging which permits display of radiological images, Electrocardiograph (ECG) tracings, imaging from other sources, and document scanning.

4. HOUSE STAFF. The house staff (otherwise known as residents) shall consist of those individuals who are graduates of medicine/osteopathic, dental, or podiatry schools, engaged in a formal program of training and education and are appointed at the Audie L. Murphy Memorial Veterans Hospital on a with or without compensation basis. They will function only under the supervision of, and within the clinical privileges as deemed appropriate by and granted to, a qualified practitioner who has clinical privileges in the area being supervised. House Staff are expected to function in a manner which is consistent with the Medical Staff Bylaws, Rules and Regulations. Unless specifically included as a voting member, they will serve as ex-officio members on designated hospital committees. Residents allowed to function outside of their training activity (e.g. hired to cover admitting area) must be granted clinical privileges through the usual credentialing process.

5. LEADERSHIP. Leadership of the South Texas Veterans Health Care System includes: The Director who is assisted by the Chief of Staff, the Deputy Chief of Staff, the Associate Director, the Assistant Director, and the Associate Director for Patient Care Services.

6. LICENSED INDEPENDENT PRACTITIONER (LIP). The term "independent practitioner" is any individual permitted by law (the statute which defines the terms and conditions of the practitioner's license) and the facility to provide patient care services independently; i.e., without supervision or direction, within the scope of the individual's license and in accordance with individually-granted clinical privileges. ***NOTE***: *Only LIPs may be granted clinical privileges.*

7. ORGANIZED MEDICAL STAFF. The Organized Medical Staff shall consist of those providers included in the category of Active Medical Staff.

8. PHYSICIAN. The term "physician" is defined as a doctor of medicine or osteopathy.

ARTICLE I. MEDICAL STAFF STRUCTURE AND ELIGILIBITY FOR MEMBERSHIP

A. The Chief of Staff serves as the Chair of the Medical Staff. The appointment and removal process for this position is addressed in VHA Handbook 5005 and Attachment A to these Bylaws (Credentialing and Privileging). There are no other officers of the Organized Medical Staff.

B. Physicians and Clinical Psychologists with appropriate privileges manage and coordinate each patient's care, treatment and services.

C. A patient's general medical condition is managed and coordinated by a doctor of medicine or osteopathy.

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

E. The Medical Staff shall be organized into the following categories:

1. Active Medical Staff (Organized Medical Staff):

(a) Physicians, dentists, optometrists, podiatrists, psychologists, and nurse anesthetists, who have an appropriate personnel appointment as a VA employee at least 4/8's time (40 hours per bi-weekly pay period) at STVHCS with professional responsibility for specific patient care and/or education and/or clinical research activities.
(b) Members of the Active Medical Staff have voting rights and except for those with administrative responsibilities and/or non-patient care research only, must have delineated clinical privileges in good standing.
(c) Active Medical Staff are expected to actively participate in appropriate medical staff meetings and activities including committees of the Medical Staff.
(d) Active Medical Staff are expected to actively participate in STVHCS performance improvement activities to improve quality of care, treatment, services and patient safety.

2. Affiliate Medical Staff:

(a) Includes the same professional disciplines as Active Medical Staff but who have an appropriate personnel appointment as a VA employee less than 4/8's time at STVHCS and/or are appointed fee basis, contract, or without compensation (WOC) with professional responsibility for specific patient care and/or education and/or clinical research activities.
(b) Members of the Affiliate Medical Staff DO NOT have voting rights and except for those with administrative responsibilities and/or non-patient care research only, must have delineated clinical privileges in good standing.
(c) Affiliate Medical Staff may attend appropriate medical staff meetings and activities including committees of the Medical Staff as designated by their supervisor and/or contract agreement.

3. Associate Medical Staff:

(a) Includes all full time, part-time, fee basis, contract or WOC clinical practitioners at STVHCS who are required by the VHA to be credentialed in VETPRO and granted a scope of practice through the Professional Standards Board of the Medical Staff. This would include but not be limited to advance practice nurses, physician assistants, chiropractors and clinical pharmacy specialists.
(b) Members of the Associate Medical Staff DO NOT have voting rights and except for those with administrative responsibilities and/or non-patient care research only, must have a scope of practice in good standing.
(c) Associate Medical Staff may attend appropriate medical staff meetings and activities including committees of the Medical Staff as designated by their supervisor and/or contract agreement.

ARTICLE II. CRITERIA AND QUALIFICATION FOR APPOINTMENT TO THE MEDICAL STAFF WITH PRIVILEGES OR SCOPE OF PRACTICE (See Attachment A, Credentialing and Privileging, of these Rules for associated details)

A. To qualify for Medical Staff membership and clinical privileges or scope of practice, individuals who meet the eligibility requirements identified in Article I, and must submit evidence as listed below. Applicants not meeting these criteria and requirements will not be considered. This determination of ineligibility is not considered a denial:

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

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

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

4. Current competence, consistent with the individual's assignment and the privileges or scope of practice for which he/she is applying.

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

6. Complete information consistent with requirements for application and clinical privileges or scope of practice as defined in Attachment A of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff

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

8. English language proficiency.

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

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

11. Ability to meet a one-hour on call response time (must be on-site within one hour of call)

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

13. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 10 work days from the request date may serve as a basis for denial of Medical Staff Appointment, privileges, and/or employment.

B. Process for Privileging and Reprivileging: (see Article VIII)

C. Code of Conduct: 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 STVHCS. Acceptable behavior includes the following (1) being on duty as scheduled; (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization; (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA; (4) not making a governmental decision outside of official channels; (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government; (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts; and (7) Respond to pager requests within 15 minutes and respond to on-call request within one hour (must be on-site within one hour of call).

D. Professional Misconduct: Behavior by a professional that creates the appearance of a violation of ethical standards or has compromised ethical standards will not be tolerated.

E. Disruptive Behavior and Inappropriate Behavior: STVHCS recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. STVHCS 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. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact. Disruptive behavior 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. Behavior by a provider that is disruptive could be grounds for disciplinary action. STVHCS distinguishes disruptive behavior from constructive criticism that is offered in a professional manner with the aim of improving patient care. Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing disruptive behavior on the part of other providers.

ARTICLE III. CLINICAL SERVICES

The following services shall be organized as components of the Medical Staff and shall have a Service Chief and/or Associate Chief of Staff responsible to the Chief of Staff or Deputy Chief of Staff for the functioning of the service and for the overall supervision of the clinical work within the service. The clinical staff of the South Texas Veterans Health Care System shall be organized into the following services:

A. Anesthesiology Service
B. Audiology and Speech Pathology Service
C. Compensation and Pension Service
D. Dental Service
E. Emergency Medicine Service
F. Geriatrics and Extended Care
G. Geriatric, Research and Education Clinic Center

H. Health Informatics Office
I. Imaging Service
J. Medical Service
K. Pathology and Laboratory Medicine Service
L. Physical Medicine and Rehabilitation Service
M. Polytrauma
N. Psychiatry Service
O. Psychology Service
P. Primary Care Service
Q. Research Service
R. Spinal Cord Injury Service
S. Surgical Service

ARTICLE IV. CLINICAL SERVICE CHIEFS

A. Qualifications: Certification by an appropriate specialty board and/or affirmatively established comparable competence through the credentialing and/or privileging process. Member of the Medical Staff and employment part-time appointment of at least 4/8s (40 hours per bi-weekly pay period). (Exceptions to qualification criteria will be considered and approved by the Chief of Staff.)

B. Selection and Appointment: The Director appoints Clinical Service Chiefs based upon the recommendations of the Chief of Staff and the appropriate Central Office Service Director and/or Professional Standards Board.

C. Roles and Responsibilities:

1. Clinically related activities of the department.
2. Administratively related activities of the department, unless otherwise provided by STVHCS.
3. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges or appointments to the Medical Staff with a scope of practice.
4. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.
5. Recommending clinical privileges for each member of the department.
6. Assessing and recommending to the relevant STVHCS authority off-site sources for needed patient care, treatment, and services not provided by the department or STVHCS.
7. The integration of the department or service into the primary functions of the organization.
8. The coordination and integration of interdepartmental and intradepartmental services.
9. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
10. The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
11. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
12. The continuous assessment and improvement of the quality of care, treatment, and services.
13. The maintenance of quality control programs, as appropriate.
14. The orientation and continuing education of all persons in the department or service.
15. Recommending space and other resources needed by the department or service.
16. Function as a member of the CEB giving guidance on the overall medical policies of the organization and making specific recommendations and suggestions regarding his/her own service in order to assure quality patient care.

17. Supervise the research, education and training programs within the service in cooperation with the chairman of the appropriate academic department(s) and the consulting and attending staffs where applicable.

ARTICLE V. CLINICAL EXECUTIVE BOARD

A. The medical executive committee of the Medical Staff of STVHCS shall be called the Clinical Executive Board (CEB). The CEB is chaired by the Chief of Staff. The CEB membership includes physician Clinical Service Chiefs as per Article III and may include other licensed independent practitioners (LIP) or non LIP Clinical Service Chiefs as approved by the Chief of Staff. Selection of voting members is per criteria outlined in Article IV, A.

B. The Organized Medical Staff delegates authority in accordance with law and regulation to the voting members of the CEB to carry out medical staff responsibilities and self-governance activities and perform the oversight activities of the Organized Medical Staff. This includes delegated authority to adopt, on the behalf of the voting members of the Organized Medical Staff, any details associated with processes of these Bylaws that are placed in these Bylaws Rules or in STVHCS policies. The CEB carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The CEB has the primary authority for activities related to self governance of the Medical Staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the Medical Staff process.

C. Membership (size and composition):

1. Voting members:

   (a) Chairperson: Chief of Staff
   (b) ACOS and Chiefs of Clinical Services (Article III)
   (c) Chief Medical Officer, Kerrville Division
   (d) Associate Chief of Staff for Education
   (e) Deputy Chief of Staff, Valley Coastal Bend (while under these Bylaws)
   (f) Deputy Chief of Staff, STVHCS

2. Non-voting members:

   (a) STVHCS Director or designee
   (b) Associate Director for Patient Care Services or designee
   (c) Chief, Social Work Service
   (d) Chief, Quality Management or designee
   (e) All members of the Organized Medical Staff, of any discipline or specialty, are eligible for consideration for ex-officio CEB membership through written request to the Chief of Staff.

D. Process for removal of members:

1. A complaint is filed with the CEB through the Chair (e.g. attendance, conduct, adverse actions against privileges, etc.). (See Article I, A., for appointment and removal of the CEB Chair.)
2. A board of inquiry is appointed by the CEB Chair, consisting of three voting members of the CEB.
3. A hearing will occur and the board will offer a recommendation to the CEB.
4. The recommendation requires 2/3 vote by CEB members for approval.

E. Meetings:

1. The CEB shall meet monthly and/or at the call of the Chair.
2. Quorum of 50 percent of voting members is required. A majority vote of the quorum is required to adopt a measure. The Chair will vote in case of a tie vote.
3. Any member of the Medical Staff has the right to bring issues to the CEB for consideration.

F. Responsibilities and Functions:

1. Empowered to act for the Organized Medical Staff between meetings of the Organized Medical Staff.
2. Report at each general medical staff meeting.
3. Act to ensure effective communication between the Medical Staff and the Director.
4. Disseminate appropriate information from medical staff meetings including the CEB to clinical support staff, administration, and the governing body. The Medical Staff may communicate with all levels of governance involved in policy decisions affecting patient care services within the VHA via appropriate channels.
5. Make recommendations to voting members of the Organized Medical Staff for amendments to these Bylaws.
6. Request evaluations of practitioners privileged through the Medical Staff process as identified in Attachment A to these Bylaws in instances where there is doubt about an applicant's ability to perform the privileges requested.
7. Perform a review of the Medical Staff Bylaws, Rules and Regulations and refer proposed changes for approval as outlined in Article XIII of these Bylaws.
8. The Organized Medical Staff through its designated mechanisms provides leadership in activities related to patient safety. Information used as part of the performance improvement mechanisms, measurement, or assessment includes Sentinel event and Patient safety data.
9. The Organized Medical Staff provides oversight in the process of analyzing and improving patient satisfaction.
10. The Organized Medical Staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the Medical Staff process such as:
    (a) Medical assessment and treatment of patients.
    (b) Use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process.
    (c) Use of medications.
    (d) Use of blood and blood components.
    (e) Operative and other procedure.
    (f) Appropriateness of clinical practice patterns.
    (g) Significant departures from established patterns of clinical practice.
    (h) The use of developed criteria for autopsies.
11. The Organized Medical Staff participates in the following activities: Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.
12. The Organized Medical Staff participates in the education of patients and families.
13. Make recommendations directly to the Director for approval on at least the following matters:
    (a) The mechanism to recommend medical staff membership termination.
    (b) Medical staff membership: appointment and reappointment to the Medical Staff including reviewing, granting, reducing and revoking, suspending, denying or terminating an appointment to the Medical Staff.
    (c) The Organized Medical Staff's structure, including committees or other activity groups.

(d) The process used to review credentials and delineate privileges, including reviewing, granting, revoking, suspending, denying or terminating clinical privileges.

(e) Departmental-specific criteria for clinical privileges and/or scope of practice and the delineation of privileges for each practitioner privileged through the Medical Staff process.

(f) Clinical services to be provided by LIPs through a telemedical link at their respective sites.

(g) Review of and recommendations for new clinical procedures and/or services, including resource assessment for privileges.

(h) Review of and actions on reports of medical staff committees, departments, and other assigned activity groups.

(i) Organization of medical staff performance improvement activities, including the mechanism used to measure, assess and improve such activities.

(j) Participation of the Organized Medical Staff in Joint Commission and other applicable survey activities.

(k) Designated mechanisms for activities related to patient safety.

(l) Mechanisms for peer review and fair hearing procedures in accordance with Veterans Health Administration directives and Federal Law (Attachment A).

(m) Adoption or revision of STVHCS policies and procedures that are specific to the Medical Staff.

(n) Recommend space and other resources needed to support STVHCS overall plan for the delivery of patient care.

ARTICLE VI. COMMITTEES UNDER THE CLINICAL EXECUTIVE BOARD

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

1. Blood Utilization Committee
2. Nutrition and Food Committee
3. Graduate Medical Education (Resident Supervision)
4. Infection Control
5. Medical Radiation & Radioisotope Committee
6. Medical Records Committee
7. Operative and Invasive Procedures Committee
8. Patient Safety Committee
9. Pharmacy and Therapeutics Committee
10. Professional Standards Board (PSB): Serves as credentials committee under the CEB. All applicants for appointment to the Medical Staff, including the review of credentials, granting of initial privileges and scopes of practice and reprivileging, will be reviewed by the PSB in accordance with VHA policy and regulations and accrediting body standards (Attachment A). The PSB submits credentialing and privileging recommendations for approval to the CEB and then to the Director. Note: Appointment actions recommended by the Professional Standards Board require a separate review for pay recommendation from a separate Compensation Panel. Local or VISN-level Compensation Panels recommend the appropriate pay table, tier level and market pay amount for individual physician and dentist medical staff members, as outlined in VA Handbook 5007.
11. Research and Development Committee.

B. Committees prepare and maintain minutes to include data, conclusions, recommendations, responsible person, actions taken, and evaluation of results of actions taken. These minutes are to be forwarded in a timely manner to the appropriate individuals with a summary to the Clinical Executive Board at a minimum on a quarterly basis.
C. Each Committee provides appropriate and timely feedback to the Services relating to all information regarding the Service and its providers.
D. The Clinical Executive Board may, by resolution and upon approval of the Director, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions or dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

ARTICLE VII. PROCESS FOR MEDICAL STAFF APPOINTMENT AND PRIVILEGES

A. The basic process steps for initial Medical Staff Appointment and Privileging are as follows:

1. The Service Chief as an agent of the organization, determines the need for recruitment of a provider through a resource assessment, obtains approval to recruit, coordinates with Human Resources to recruit qualified individuals, and collaborates with the affiliate organization as to candidates for selection.
2. The Service Chief recommends the final applicant to Human Resources to initiate the hiring process and to the Medical Staff Office to initiate the credentialing and privileging process. Note: contract staff are initiated through the contract agreement and recommended for privileging by the Service Chief.
3. The Medical Staff Office contacts the applicant; sends required documents via mail carrier or via electronic message; enrolls the applicant in the Vetpro credentialing database; monitors timelines for completion of actions; and performs primary source verification on required credentials (see Article II).
4. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 10 work days from the request date may serve as a basis for denial of Medical Staff Appointment, privileges, and/or employment.
5. Complete credentialing and privileging files are presented to the Service Chief for review and approval/disapproval in Vetpro, and then to the Professional Standards Board for review. Human Resource representatives participate in the Professional Standards Board for technical review of employment requirements.
6. The Professional Standards Board recommends actions to the Clinical Executive Board. The Clinical Executive Board recommends actions to the Director.
7. Appointments to the Medical Staff should be acted upon by the Director within 45 calendar days of receipt of a fully complete application including application for clinical privileges and all required verifications, references, and recommendations from the appropriate service chief and the Professional Standards Board. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment (with reason provided).

B. The STVHCS is a part of the VHA and as such is subject to the regulations of the VHA and applicable federal law and accrediting body regulations. Attachment A to these Bylaws, VHA Handbook 1100.19 provides the associated details on medical staff appointment and privileging.

C. Appointments to the Medical Staff occur in conjunction with VA employment or utilization under a VA contract or sharing agreement. Initial and certain other employment appointments made under Title 38 U.S.C. 7401(1), 7401 (3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance and conduct will be closely evaluated under applicable STVHCS and VHA policies and procedures.

D. To be complete, applications for appointment must be submitted by the applicant via VetPro (electronic credentialing program) and on forms approved by STVHCS and include items specified in Article II and Attachment A of these Bylaws and Rules.

E. The ACOS, Geriatrics and Extended Care is responsible for recommending appointment to the Medical Staff based on a review of the qualifications of any practitioner who will provide direct patient care to patients in any long term care or home care program. Practitioners who provide only consultative services for long term care patients are excluded from this requirement.

F. Temporary Medical Staff Appointments and Privileges for Urgent Patient Care Needs.

1. Temporary medical staff appointment and privileges may be granted for urgent patient care needs. Examples include:
   (a) A situation where a physician becomes ill, takes a leave of absence, or resigns appointment and a physician would need to cover that physician's practice.
   (b) A situation where a specific provider with specific skill is needed to augment the care to a patient that the patient's current privileged provider does not possess.
2. The temporary appointment may be made by the STVHCS Director prior to receipt of references or verification of other information and action by the Professional Standards Board. Minimum required evidence includes:
   (a) Verification of at least one, active, current, unrestricted license with no previous or pending actions;
   (b) Confirmation of current comparable clinical privileges;
   (c) Response from NPDB-HIPDB PDS registration with no match;
   (d) Response from FSMB with no reports;
   (e) Receipt of at least one peer reference who is knowledgeable of and confirms the provider's competence, and who has reason to know the individual's professional qualifications; and
   (f) Documentation by the STVHCS Director of the specific patient care situation that warranted such an appointment.
3. An application through VetPro must be completed within 3 calendar days of the date the appointment is effective. This includes Supplemental Questions, a Declaration of Health, and a Release of Information.
4. If the Temporary appointment is not converted to another form of medical staff appointment, complete credentialing must be completed, even if completion occurs after the practitioner's temporary appointment is terminated or expires. If unfavorable information is discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.
5. Temporary appointments for urgent patient care needs may not exceed 60 days.

G. Nothing precludes VA from terminating a practitioner in accordance with VA Handbook 5021 procedures when the separation is not for a professional reason (see procedures in Attachment A). Health care professionals appointed under authority of 38 U.S.C. 7405 may be terminated in accordance with VA Directive and Handbook 5021, when this is determined to be in the best interests of VA.

ARTICLE VIII. PROCESS FOR CREDENTIALING, RECREDENTIALING, PRIVILEGING, REPRIVILEGING, AND REAPPOINTMENT.

A. As a self-governance function, all licensed independent practitioners (LIPs) credentials and privileges are reviewed by the Organized Medical Staff (delegated to the CEB) as per process steps in Article II, Article

VII, and item B below. Physician Assistants, Advanced Practice Nurses, Chiropractors and Clinical Pharmacy Specialists (Associate Medical Staff) are credentialed and granted a scope of practice through the same process as LIPs. Practitioners practice only within the scope of their privileges as determined through ongoing professional practice evaluation.

B. Recredentialing, Reprivileging, and Reappointment basic process steps (See Attachment A for associated details):

1. The Service Chief as an agent of the organization recommends renewal of privileges, scopes of practice, and Medical Staff Appointment to include resource assessment and review of time limited appointment agreements such as contract, fee basis or without compensation.

2. Reappraisal is the process of evaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the STVHCS. The reappraisal process must include: the practitioner's statements regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction or loss of privileges at another hospital; loss of medical staff membership; pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment; mental and physical status; and any other reasonable indicators of continuing qualification and competency. Additional information regarding current and/or changes in licensure and/or registration status; NPDBHIPDB PDS registration and report results; peer recommendations; continuing medical education; and verification regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review.

3. The Medical Staff Office contacts the applicant; sends required documents via mail carrier or via electronic message; enrolls the applicant in the Vetpro credentialing database; monitors timelines for completion of actions; and performs primary source verification on required credentials.

4. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 10 work days from the request date may serve as a basis for denial of Medical Staff Appointment, privileges, and/or employment.

5. Complete credentialing and privileging files are presented to the Service Chief for review and approval/disapproval in Vetpro, and then to the Professional Standards Board for review. Human Resource representatives participate in the Professional Standards Board for technical review of employment requirements.

6. The Professional Standards Board recommends actions to the Clinical Executive Board. The Clinical Executive Board recommends actions to the Director.

C. Clinical privileges and scopes of practice are granted for a period not to exceed 2 years. Clinical privileges are not to be extended beyond the 2-year period, which begins from the date the privileges are signed, dated, and approved by the Director. Clinical privileges and scopes of practice granted to contract, without compensation or fee basis providers may not extend beyond the agreement period.

D. All Medical Staff Members shall participate in continuing education as a requirement for renewal of privileges as described in these Bylaws Rules under the section Education. All members of the Medical Staff are required to show proof of current Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) training at the time of credentialing and privileging and re-privileging. (See Bylaws, Rules, Education Section for associated details on required ACLS training). In an emergency, any medical staff member with clinical privileges or scope of practice is permitted to provide any type of patient care, treatment and services necessary as a life-saving measure or to prevent serious harm—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual's license. Properly supervised Members of the House Staff may also provide emergency care

within their training scope of practice.

E. Disaster Privileges: Internal/External Disaster privileges may be granted when STVHCS has activated the emergency management plan, and STVHCS is unable to handle the immediate patient needs. The process for granting disaster privileges will follow the structure of the Hospital Incident Command System (see associated details in Attachment A).

F. Ongoing Professional Practice Evaluation is required to maintain privileges. Evaluations include written information (evidence-based evaluation of competence) regarding the practitioners current general competencies in patient care, medical/clinical knowledge, clinical judgment, interpersonal skills, professionalism, systems-based practice, and technical/clinical skills. Information will be obtained from STVHCS sources and from other healthcare organizations (for low volume providers) per approved business agreements. The Service Chief determines the nature and frequency of ongoing Professional Practice Evaluations appropriate to evaluate patient care and services provided by practitioners beyond the minimum requirement as per STVHCS policy.

G. Focused Professional Practice Evaluation is a time limited, service specific process for obtaining additional information to confirm competency to perform clinical privileges.

1. All practitioners applying for initial privileges to practice for the South Texas Veterans Health Care System (STVHCS) must successfully complete a maximum 90-day Focused Professional Practice Evaluation (FPPE). Active STVHCS practitioners who request new privileges may need to complete a FPPE. Active practitioners who meet defined criteria for performance monitoring must complete a FPPE for the privilege or privileges that triggered the need for the performance monitoring. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege.

2. Triggers are events or occurrences that may indicate the need for performance monitoring. Triggers can be single incidents (sentinel events as described by Joint Commission); evidence of a clinical trend (such as exceeding twice the average 30 day case mortality rate as tabulated by NSQIP in its most recent report); Level Three findings on an unprotected peer review; one (1) Level Three or two (2) Level Two findings on peer review reports within a six month period; any unsatisfactory rating on a Peer Recommendation Form or Professional Practice Evaluation Report; or a validated quality of care issue resulting in a Congressional Investigation, Office of Medical Inspector (OMI) review, Administrative Investigation Board (AIB), or Office of Inspector General (OIG) review. Triggers may also result from negative trends identified in provider specific and/or aggregate clinical data and/or from lack of organizational data to support privileges (low volume).

Methods for Monitoring may include (as determined by the Service Chief):

(a) Medical record review-a minimum of 5 records related to the privileges requested.
(b) Review of clinical practice patterns (management of specific medical conditions as compared to clinical practice guidelines and/or peers of the same profession and specialty)
(c) Simulation (direct observation of simulation of a procedure(s) with documentation of competence to perform the procedure(s)
(d) Proctoring (direct observation of procedure(s) with documentation of competence to perform the procedure(s)
(e) Discussions with other health care professionals- This method requires documentation of feedback.
(f) Unprotected peer review-a minimum of 5 records related to the privileges requested, utilizing the format as described in the organizational policy on peer review for Quality Management with assignment of Level 1, Level 2, or Level 3.

(g) Practitioners external to STVHCS may be solicited to conduct the FPPE in instances when the Service Chief is the practitioner under review and/or when there is a lack of an internal practitioner in the same profession with the privileges and expertise to conduct the evaluation or under circumstances of conflict of interest.

3. Failure of a practitioner to accept the criteria for the focused professional practice evaluation will result in new privileges not being granted or additional actions taken as appropriate, for currently privileged providers.

4. A practitioner who fails to provide appropriate evidence-based data to complete the Professional Practice Evaluation and to document evidence based competency shall be deemed to have voluntarily relinquished Medial Staff membership and clinical privileges. The practitioner may initiate application for privileges when evidence-based data is available to support the requested privileges.

ARTICLE IX. HISTORY AND PHYSICAL EXAM:

A. The minimal content of the history and physical exam will include sufficient information to identify the patient, to support the diagnosis, to justify the treatment and to document the results accurately (see Rules of these Bylaws for associated details).

B. Inpatient Admission: A medical history and physical examination (H&P) are completed (written and signed) no more than 30 days prior to or within 24 hours after inpatient admission. If an H&P has been performed within 30 days prior to admission and recorded in the electronic medical record, an update progress note must be completed which includes a reference to the H&P by specific date in addition to updates to the patient's medical condition. This progress note must be completed within 24 hours of admission or prior to the surgery or a procedure requiring anesthesia services, whichever comes sooner.

C. The H&P and required updates are the responsibility of the admitting physician or oralmaxillofacial surgeon Medical Staff Member with approved privileges.

D. House Staff (physicians and oralmaxillofacial surgery residents) may complete and sign the H&P to meet the standard of 24 hours after admission.

E. A Medical Staff Member supervising physician (doctor of medicine or osteopathy) may delegate all or part of the medical history and physical examination to a Physician Assistant or Advanced Practice Nurse who has those duties approved on a current scope of practice. The physician who delegated the H&P must meet all required H&P elements.

F. The supervising physician must physically meet, examine, and evaluate the patient within 24 hours of admission including weekends and holidays. Documentation of the supervising physician's findings and recommendations regarding the H&P and treatment plan must be in the form of an independent progress note or an addendum to the House Staff, Physician Assistant or Advanced Practice Nurse note and must be entered by the end of the calendar day following admission. The time requirement for seeing and evaluating the patient is different from that of documentation in the medical record by the supervising practitioner.

ARTICLE X. CORRECTIVE ACTIONS AND FAIR HEARING

A. Indications and Process for Corrective actions and fair hearing procedures are as follows (see Attachment A for associated details):

1. Automatic Suspension:

(a) Indication: Privileges may be automatically suspended for administrative reasons

which may occur in instances where the provider is behind in dictation, or allowed a license to lapse and therefore does not have an active, current, unrestricted license. Such instances must be weighed against the potential for substandard care, professional misconduct, or professional incompetence. Under no circumstances should there be more than three automatic suspensions of privileges in 1 calendar year, and no more than 20 days per calendar year. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in a calendar year, a thorough assessment of the need for the practitioner's services needs to be performed and documented and appropriate action taken.

(b) Process: The Chief of Staff (COS) upon recommendation of the CEB may automatically suspend privileges. The provider will receive verbal notification of the indication and terms of the automatic suspension from the Service Chief and written notification from the COS. Once the terms of the automatic suspension are met, the privileges will be restored upon recommendation of the COS and the Clinical Executive Board.

2. Summary Suspension:

(a) Indication: Clinical privileges may be summarily suspended when there is sufficient concern regarding patient safety or specific practice patterns and the failure to take such an action may result in an imminent danger to the health of any individual.

(b) Process: The Director, on the recommendation of the COS, may summarily suspend privileges, on a temporary basis. The comprehensive review of the reason for summary suspension must be accomplished within 30 calendar days of the suspension with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to the Director for consideration and action. The Director must make a decision within 5 working days of receipt of the recommendations. This decision could be to exonerate the practitioner and return privileges to an active status, or that there is sufficient evidence of improper professional conduct or incompetence to warrant proceeding with a reduction or revocation process.

3. Reduction or Revocation:

(a) Indication: Reduction or revocation of privileges may be related to deficiencies in professional performance i.e. professional competence or professional conduct. A reduction of privileges may include restricting or prohibiting performance of selected specific procedures, including prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically-disabling condition or further training in a particular area. Revocation of privileges refers to the permanent loss of clinical privileges.

(b) Reduction Process: The COS notifies the provider in writing of the proposed changes in privileges and reason for the change. The provider must be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the provider must submit a response within 10 workdays of the COS's written notice. All information is forwarded to the Director for decision. The Director must make, and document, a decision on the basis of the record. If the practitioner disagrees with the Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 workdays after receipt of decision. The Director must appoint a review panel of three professionals, within 5 workdays after receipt of the practitioner's request for hearing, to conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must

be a member of the same specialty. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. The Director has the authority to accept, reject, accept in part, or modify the review panel's recommendations. The Director must issue a written decision within 10 workdays of the date of receipt of the panel's report. If the practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the Director constitutes a final action and the reduction is reportable to the NPDB. The provider may appeal to the VISN Director within 5 workdays of receipt of the Director's decision. The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the practitioner's appeal. The VISN Director's decision is final.

(c) Revocation Process: Recommendations to revoke a practitioner's privileges must be made by the CEB of the Medical Staff, based upon review and deliberation of clinical performance and professional conduct information. A revocation of privileges requires removal from both employment appointment and appointment to the Medical Staff, unless there is a basis to reassign the practitioner to a position not requiring clinical privileges. When revocation of privileges is proposed and combined with a proposed demotion or dismissal, the due process rights of the practitioner must be accommodated by the hearing provided under the dismissal process. Where removal is proposed, the due process procedures for removal and revocation of privileges must be combined. Dismissal constitutes a revocation of privileges. When revocation of privileges is proposed and not combined with a proposed demotion or dismissal, the due process procedures under reduction of privileges must pertain.

4. If the practitioner's clinical privileges are pending renewal and due to expire during a summary suspension or due process procedures for reduction or revocation, the clinical privileges must be denied pending outcome of the review and due process procedures. This denial is considered administrative until such time as a final decision is made in the summary suspension or due process procedures.

5. Management Authority: Nothing in these procedures restricts the authority of management to temporarily detail or reassign a practitioner to non-patient care areas or activities, thus in effect suspending privileges while the proposed reduction of privileges or discharge, separation, or termination is pending.

B. Acceptance of membership on the Medical Staff shall constitute the member's assurance that he/she will abide by the principles of ethics promulgated by applicable professional licensing and/or regulatory bodies of the VHA. In case of a complaint about the professional, moral or ethical behavior of any member of the Medical Staff, the Chief of Staff has the right and duty to investigate and advise the Director accordingly.

C. Management of Impaired or Disruptive Provider

1. The term "disruptive" or "impaired" applies to a provider whose behaviors or practice patterns are compromised by external influences, such as substance abuse, environmental stress or emotional distress. STVHCS endorses "zero tolerance" for intimidating or disruptive behavior. Disruptive/Inappropriate behavior is conduct by an individual working in the organization that intimidates others to the extent that quality of patient care and safety could be compromised. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) These behaviors may be verbal and non-verbal, may involve the use of rude language, may be threatening, or may involve physical contact.

2. Reporting and Referral of the Impaired or Disruptive Provider:

(a) Licensed independent practitioners may self-refer to a program for assistance for psychiatric, emotional or physical problems. Assistance in the self -referral may be obtained from the supervisor or the Chief of Staff.

(b) Any individual within the organization has the responsibility to report concerns regarding providers who appear to be providing unsafe treatment to patients. These reports are to be made directly to the provider's Service Chief or to the Chief of Staff. Reports may also be made directly to the Director.

3. As per STVHCS policy, the Impaired Provider Committee (IPC) will evaluate and recommend appropriate action for the impaired or disruptive provider whose behavior(s) can negatively affect patient care. While the goal of this process is to provide assistance rather than disciplinary action, in some instances, the IPC may recommend discipline as a necessary action to improve or resolve quality of patient care issues.

4. If compliance with treatment program monitoring is required, the IPC will determine the method of monitoring. Monitoring will continue until the IPC is able to verify that the impairment for which the provider was referred to the program no longer exists, or no longer impacts the quality of patient care provided by the individual, or continues due to noncompliance with the recommended plan. In the case of noncompliance, the IPC will recommend action to privileges of the impaired provider and/or disciplinary action.

ARTICLE XI. MEETINGS OF THE ORGANIZED MEDICAL STAFF

A. Regular Meetings: Meetings are held at least annually at the call of the Chief of Staff. A record of attendance shall be kept.

B. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the Clinical Executive Board. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to include electronic message to the Medical Staff at least forty-eight (48) hours prior thereto. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Director in writing and stating the reason(s) for the request.

C. Quorum: For purposes of Medical Staff business, 25 percent of the total membership of the Medical Staff membership entitled to vote constitutes a quorum.

ARTICLE XII. RULES

As a self-governance function, the Organized Medical Staff, through delegated authority to the CEB, shall adopt such Rules and regulations as may be necessary to implement more specifically the general principles found within the guidelines of the governing body. These Rules and regulations specifically relate to the role of individuals with clinical privileges or scope of practice in the care of patients receiving medical treatment in STVHCS and shall be a part of these Bylaws.

ARTICLE XIII. AMENDMENTS TO THE BYLAWS AND RULES

A. As a self-governance function, the Medical Staff Bylaws and Rules are adopted and amended by the Organized Medical Staff. These Bylaws and Rules shall be revised by amendment when necessary to ensure that they reflect current practices with respect to medical staff organization and functions. At a minimum, the Bylaws and Rules shall be reviewed by the Organized Medical Staff and the CEB at least every two years (from the Director's approval date). Proposed amendments to these Bylaws and Rules may be submitted in writing to the Chief of Staff by any clinical service chief or any member of the Medical Staff. Proposed amendments will be coordinated by the Chief of Staff and distributed to the members of the Organized Medical Staff for review. A period of not less than 15 calendar days will be allowed for receipt of written comments from the Organized Medical Staff on proposed changes.

B. Bylaws and Rules may be amended or repealed at any regular meeting of the Organized Medical Staff by majority vote of a quorum of 25 percent of the total membership of the Medical Staff membership entitled to vote, or at any meeting of the CEB by a majority vote of a quorum (50 percent) of voting members. The recommendation(s) will then be forwarded to the Director and will become effective when approved by the Director. Neither the Organized Medical Staff nor the Director may unilaterally change the Bylaws or Rules.

ARTICLE XIV. ADOPTION / RESCISSION

The adoption of these Bylaws together with the appended Rules rescinds the formerly adopted Medical Staff Bylaws dated June 4, 2009.

Recommended for approval by the Clinical Executive Board on June 30, 2010.

RECOMMEND APPROVAL:

\\SIGNATURE ON FILE

NICOLAS E. WALSH, M.D.
Acting Chief of Staff
Date: 7/6/2010

APPROVED / DISAPPROVED:

\\SIGNATURE ON FILE

MARIE L. WELDON, FACHE
Director
Date: 7/5/2010

Attachment A

CREDENTIALING AND PRIVILEGING

1. PURPOSE: To provide policy and procedure within VHA and Joint Commission regulations for credentialing and privileging of all health care professionals who are permitted by law and the South Texas Veterans Health Care System (STVHCS) to practice independently.

2. POLICY:

a. All VHA health care professionals who are permitted by law and the STVHCS to provide patient care services independently must be credentialed and privileged as defined in VHA Handbook 1100.19 and Medical Staff Bylaws. The requirements of The Joint Commission (TJC) standards and VHA policies have been used to define the processes for credentialing, privileging, reappraisal, re-privileging, and actions against clinical privileges, including denial, failure to renew, reduction, and revocation. This Policy applies to all licensed independent practitioners permitted by law and STVHCS to provide direct patient care, including telemedicine, and who are appointed or utilized on a full-time, part-time, intermittent, consultant, attending, without compensation (WOC), on-station fee-basis, on-station contract, or on-station sharing agreement basis.

b. The credentialing, but not privileging, requirements of this Policy apply to all Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), Clinical Pharmacy Specialists, and Chiropractors even though these practitioners may not practice as licensed independent practitioners, as well as physicians, dentists, and other practitioners assigned to research or administrative positions not involved in patient care. All Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), Clinical Pharmacy Specialists, and Chiropractors will be considered for a scope of practice under the same guidelines as privileging.

c. Policy and procedures related to the denial, failure to renew, reduction, and revocation of clinical privileges, where based on professional competence, professional misconduct, or substandard care, apply to all health care professionals who are granted privileges within the scope of this policy.

d. VetPro is VHA's electronic credentialing system and must be used for credentialing all providers who are granted clinical privileges or are credentialed for other reasons. One component of VHA's Patient Safety Program is quality credentialing and the use of VetPro is necessary to reduce the potential for human error in the credentialing process. In addition, documentation other than in VetPro that is required by VHA Handbook 1100.19, must be maintained in a paper or electronic medium. The requirements of this policy are the same whether carried out on paper or electronically. For example, if a signature is required and the mechanism in use is electronic, then that modality must provide for an electronic signature.

e. Credentialing and privileging must be completed prior to initial appointment or reappointment to the Medical Staff and before transfer from another medical facility. If the primary source verification(s) of the practitioner's credentials are on file (paper or electronic), those credentials that were verified at the time of initial appointment (and are not time-limited or specifically required by this policy or TJC to be updated or re-verified) can be considered verified.

f. All procedures described in this Policy are applicable to Chiefs of Staff (COS) and STVHCS Directors who are involved in patient care. Differences in specific procedures are noted where applicable.

3. DEFINITIONS

a. **Appointment.** The term "appointment" refers to the Medical Staff. It does not refer to appointment as a VA employee (unless clearly specified), but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority for providing patient care services at the STVHCS. Both VA employees and contractors may receive appointments to the Medical Staff.

b. **Associated Health Professional.** The term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine.

c. **Authenticated Copy.** The term "authenticated copy" means that each page of the document is a true copy of the original document; each page is stamped "authenticated copy of original" and is dated and signed by the person doing the authentication. NOTE: Facsimile copies of verification documents may not be used for final verification.

d. **Credentialing**. The term "credentialing" refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, and current competence and health status.

e. **Clinical Privileging.** The term "clinical privileging" is defined as the process by which a

practitioner, licensed for independent practice (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.), is permitted by law and the STVHCS to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure. Clinical privileges must be STVHCS-specific and provider-specific. *NOTE: There may be practitioners, who by the nature of their position, are not involved in patient care (i. e., researchers or administrative physicians). These health care professionals must be credentialed, but may not need to be privileged.*

f. **Competency.** Competency is documented demonstration of an individual having the requisite or adequate abilities or qualities capable to perform up to a defined expectation.

g. **Current.** The term "current" applies to the timeliness of the verification and use for the credentialing and privileging process. No credential is current and no query of the Federation of State Medical Boards (FSMB) is current if performed prior to submission of a complete application by the practitioner to include submission of VetPro. At the time of initial appointment, all credentials must be current within 180 days of submission of a complete application. For reappointment, all time-limited credentials must be current within 180 days of submission of the application for reappointment including peer appraisals, confirmation of National Practitioner Data Bank (NPDB)-Health Integrity and Protection Data Bank (HIPDB) Proactive Disclosure Service (PDS) annual registration, and other credentials with expirations.

h. **Independent Practitioner.** The term "independent practitioner" is any individual permitted by law (the statute which defines the terms and conditions of the practitioner's license) and the STVHCS to provide patient care services independently; i.e., without supervision or direction, within the scope of the individual's license and in accordance with individually-granted clinical privileges. This is also referred to as a licensed independent practitioner (LIP*). NOTE: Only LIPs may be granted clinical privileges.*

i. **Licensure.** The term "licensure" refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State, Territory, Commonwealth, or the District of Columbia (hereafter, "State") in the form of a license, registration, or certification.

j. **One Standard of Care.** The term "one standard of care" means that one standard of care must be guaranteed for any given treatment or procedure, regardless of the practitioner, service, or location within the STVHCS. In the context of credentialing and privileging, the requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same.

k. **Post-graduate (PG).** The term PG is the acronym for post-graduate.

l. **Primary Source Verification.** Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be documented in the form of a letter, documented telephone contact, or secure electronic communication with the original source.

m. **Proctoring.** Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations. The proctor must have clinical privileges for the activity being performed, but must not be directly involved in the care the observed practitioner is delivering. Proctoring that requires a proctor to do more than just observe, i.e., exercise control or impart knowledge, skill, or attitude to another practitioner to ensure appropriate, timely, and effective patient care, constitutes supervision. Such supervision may be a reduction of privileges (see the NOTE following subpar. 6j(2) for additional information).

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

o. **Telemedicine.** Telemedicine is the provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient. *NOTE: A crucial consideration in making a distinction between consultation and care is that teleconsultation occurs when the consultant involved recommends diagnoses, treatments, etc., to the consulting provider requesting the consult, but does*

not actually write orders or assume the care of the patient. If the consultant diagnoses, writes orders, or assumes care in any way, this constitutes "care" and requires privileges. A Medical Staff appointment is required if the provider is entering documentation into the medical record, e.g., teleradiology, teledermatology, etc.

p. **VetPro.** VetPro is an Internet enabled data bank for the credentialing of VHA health care providers that facilitates completion of a uniform, accurate, and complete credentials file.

4. RESPONSIBILITIES

a. Director. The ultimate responsibility for credentialing and privileging resides with the STVHCS Director. The STVHCS Director, designated by the Under Secretary for Health as the Governing Body of the STVHCS, is responsible for ensuring:

(1) The labor-management obligations are met prior to implementing a Credentialing and Privileging Program that involves Title 5 independent practitioners who are represented by a professional bargaining unit.

(2) Local STVHCS policy, including Medical Staff Bylaws, Rules, and Regulations, is consistent with the VHA Handbook 1100.19.

(3) Medical staff leadership and all staff with responsibility in the credentialing and privileging process complete the one-time only training as determined by the Office of Quality and Performance (OQP). Training must be completed within 3 months of assuming this position. This training may be accessed through the VA Learning Management System at http://www.lms.va.gov . This target audience includes: Medical Staff and Credentialing Professionals; Service and Product Line Chiefs; Credentials Committee Members (Professional Standards Boards); Medical CEB Members; COSs and Medical Directors; Quality and Performance Improvement Professionals; and Risk Managers.

b. STVHCS COS. The STVHCS COS is responsible for:

(1) Maintaining the Credentialing and Privileging system and ensuring that all health care professionals applying for clinical privileges agree to provide continuous care to the patients assigned to them and are provided with a copy of, and agree to abide by the Medical Staff Bylaws, Rules, and Regulations; and ensuring that the Medical Staff Bylaws are consistent with the VHA Handbook 1100.19 and any other VHA policy related to Medical Staff Bylaws.

(2) Completing training identified in subparagraph 4c(3) and ensuring that appropriate staff in direct line of authority complete the training.

c. Service Chiefs

(1) Service chiefs are responsible for:

(a) Recommending the criteria for clinical privileges that are relevant to the care provided in the service;

(b) Reviewing all credentials and requested clinical privileges, and for making recommendations regarding appointment and privileging action; and

(c) A continuous surveillance of the professional performance of those who provide patient care services with delineated clinical privileges.

(2) Service Chiefs involved in the credentialing and privileging process are responsible for completing training identified in subparagraph 4c(3) and ensuring that appropriate staff in direct line of authority complete the training.

d. Applicant and Practitioner. Applicants and appointed practitioners must provide evidence of licensure, registration, certification, and/or other relevant credentials, for verification prior to appointment and throughout the appointment process, as requested. They must agree to accept the professional obligations delineated in the Medical Staff Bylaws, Rules, and Regulations provided to them. They are responsible for keeping VA apprised of anything that would adversely affect, or otherwise limit, their clinical privileges. ***NOTE:*** *Failure to keep VA fully informed on these matters may result in administrative or disciplinary action.*

5. CREDENTIALING *(i.e., the Initial Appointment, Reappointment, or Reappointment after a Break in Service)*

a. **Provisions.** Health care professionals must be fully credentialed and privileged prior to initial appointment or reappointment, except as identified in subparagraphs 5o, 5p, 6e, and 6f.

b. **Procedures.** Credentialing is required to ensure an applicant has the required education, training, experience, physical and mental health, and skill to fulfill the requirements of the position and to support the requested clinical privileges. This paragraph contains the administrative requirements and procedures related to the initial credentialing and reappraisal of practitioners who plan to apply for clinical privileges.

(1) The credentialing process includes verification, through the appropriate primary sources, of the individual's professional education; training; licensure; certification and review of health status; previous experience, including any gaps (greater than 30 days) in training and employment; clinical privileges; professional references; malpractice history and adverse actions; or criminal violations, as appropriate. Except as identified in subparagraph 5a., medical staff and employment commitments must not be made until the credentialing process is completed, including screening through the appropriate State Licensing Board (SLB), FSMB, and the NPDB-HIPDB. All information obtained through the credentialing process must be carefully considered before appointment and privileging decision actions are made.

(2) The applicable service chief reviews the credentialing folder and requested privileges and make recommendations regarding appointment. The folder and recommendations are reviewed by the credentialing committee and then submitted with recommendations to the Medical Staff's CEB.

(3) All new applicants applying for clinical privileges must be provided with a copy of the Medical Staff Bylaws, Rules, and Regulations and must agree in writing to accept the professional obligations reflected therein. All renewal applicants must attest to the Medical Staff Bylaws through VetPro.

(4) The applicant has the burden of obtaining and producing all needed information for a proper evaluation of professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any questions concerning these qualifications. Failure to provide necessary information, within 10 work days within the request date, may serve as a basis for denial of medical staff appointment and/or privileges.

c. **Application Forms.** Candidates seeking appointment or reappointment must complete the appropriate forms for the position for which they are applying.

(1) All candidates, requiring credentialing in accordance with this policy, must complete an electronic submission of VetPro. VetPro's supplemental information form requests applicants to answer questions to meet TJC and VHA requirements. This supplemental information form requires the applicant to provide information concerning malpractice, adverse actions against licensure, privileges, hospital membership, research, etc.

(2) The "Sign and Submit" screen in VetPro addresses the applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the STVHCS to which the application is being made, as well as attesting to the accuracy and completeness of the information submitted.

(3) Applicants are required to provide information on all educational, training, and employment experiences, including all gaps greater than 30 days in the candidate's history.

(4) If the delay between the candidate's application and reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information including, but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to the candidate reporting for duty. Verification of a time-limited credential cannot be greater than 120 days old at the time a practitioner reports for duty. This requirement includes a response from the NPDB–HIPDB.

NOTE: *Delays between a candidate's application and reporting for duty most frequently occur in the case of an individual for whom special waivers (i.e., visa waiver) may be required. Since these processes can be time consuming, information on the candidate's practice or non-practice during the period of delay must be obtained in order to ensure the most appropriate placement of the candidate.*

NOTE: *A copy of the appropriate application form and any supplemental form(s) are maintained electronically in VetPro and may be filed in Section I of the credentialing and privileging folder. If the applicant provides a resume or curriculum vitae, this is also filed in Section I.*

d. **Documentation Requirements**

(1) Each privileged health care practitioner must have a Credentialing and Privileging file established electronically in VetPro with any paper documents maintained in file in accordance with VHA Handbook 1100.19.

(2) Information obtained, to be used in the credentialing process, must be primary source verified in accordance with VHA Handbook 1100.19.

(3) There must be follow-up of any discrepancy found in information obtained during the verification process. The practitioner has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously-provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the practitioner says the information provided is factually incorrect.

(4) Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and of informing the STVHCS Service Chief or designee of any changes in the status of these credentials. The Chief of Staff or designee, is responsible for establishing a mechanism to ensure that multiple licenses, registrations, and/or certifications are consistently held in good standing or, if allowed to lapse, are relinquished in good standing. The practitioner is required to provide a written explanation for any credentials that were held previously, but which are no longer held or no longer full and unrestricted. The verifying official must contact the State board(s) or issuing organization(s) to verify information provided regarding the change. ***NOTE:*** *There are circumstances when verification from a foreign country is not possible or could prove harmful to the practitioner and/or family. In these instances, full documentation of efforts and circumstances, including a statement of justification, is to be made in the form of a report of contact and filed in the Credentialing and Privileging file in lieu of the document sought.*

(5) If the search for documents is unsuccessful or the primary source documents are not received, after a minimum of two requests, full written documentation of these efforts, in the form of a report of contact, must be placed in the folder in lieu of the document sought. It is suggested that no more than 30 days elapse before the attempt is deemed unsuccessful. The practitioner needs to be notified and to assist in obtaining the necessary documentation through a secondary source.

e. **Educational Credentials**

(1) Verification of Educational Credentials

(a) For health care professionals who are requesting clinical privileges, primary source verification of all internships (if applicable), residencies, fellowships, advanced education, clinical practice programs, etc., from the appropriate program director or school is required.

(b) For foreign medical school graduates, STVHCS officials must verify with the Educational Commission for Foreign Medical Graduates (ECFMG) that the applicant has met requirements for certification, if claimed. The ECFMG is not applicable for graduates from Canadian or Puerto Rican medical schools. Documentation of completion of a "Fifth Pathway" may be substituted for ECFMG certification. Additionally, TJC accepts the primary source verification of ECFMG for foreign medical school graduation.

(c) All efforts to verify education must be documented if it is not possible to verify education, e.g., the school has closed, the school is in a foreign country and no response can be obtained, or for other reasons. In any case, STVHCS officials must verify and document that candidates meet appropriate VA qualification standard educational requirements prior to appointment as an employee.

(d) Applicants are required to provide information on all educational and training experiences, including all gaps greater than 30 days in educational history.

(e) For other health care providers, at a minimum, the level of education that is the entry level for the profession or permits licensure must be verified, as well as all other advanced education used to support the granting of clinical privileges, if applicable (e.g., for an APRN, the qualifying degree for the registered nurse (RN) and the advanced APRN education must be verified).

f. **Verifying Specialty Certification**

(1) Physician Service Chiefs

(a) Physician service chiefs must be certified by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty(ies) not appropriate for the assignment, the Medical Staff's Clinical Executive Board (CEB) affirmatively establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. Appointment of service chiefs without board certification must comply with the VHA policy for these appointments as appropriate.

(b) Verification must be from the primary source in accordance with VHA Handbook 1100.19.

(c) Evidence of Continuing Certification. Board certification and other specialty certificates, which are time-limited or carry an expiration date, must be reviewed and documented prior to expiration.

g. **Licensure**

(1) Requirement for Full, Active, Current, and Unrestricted Licensure. Applicants being credentialed in preparation for applying for clinical privileges must possess at least one full, active, current, and unrestricted license that authorizes the licensee to practice in the state of licensure and outside VA without any change being needed in the status of the license. ***NOTE:*** *For new appointments after a break in service, all licenses active at the time of separation need to be primary source verified for any change in status.*

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

(a) Applicants and individuals appointed on or after November 30, 1999, who have been licensed, registered, or certified (as applicable to such position) in more than one State and who had such license, registration, or certification revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for appointment, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status. ***NOTE:*** *Covered licensure actions are based on the date the credential was required by statute or the position's qualification standards. For example, if VA first required the credential in 1972, the individual lost the credential in 1983, and the individual applies, or was appointed, to VA after November 30, 1999, the individual is not eligible for VA employment in the covered position, unless the lost or surrendered credential is restored to a full and unrestricted status. However, if the individual lost the credential in 1970, before it was a VA requirement, eligibility for VA employment would not be affected provided the individual possesses one full and unrestricted license as applicable to the position (see App. B for list of occupations, job series, type of credential, and date first required by VA).*

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

(c) Where a license, registration, or certification (as applicable to the position) has been surrendered, confirmation must be obtained from the primary source that the individual was notified in writing of the

potential for termination for professional misconduct, professional incompetence, or substandard care. If the entity does verify written notification was provided, the individual is not eligible for employment unless the surrendered credential is fully restored.

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

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

(3) When a practitioner enters into an agreement (disciplinary or non-disciplinary) with a State licensing board to not practice the occupation in a State, the practitioner is required to notify VA of the agreement. VA must obtain information concerning the circumstances surrounding the agreement. This includes information from the primary source of the specific written notification provided to the practitioner, including, but not limited to: notice of the potential for termination of licensure for professional misconduct, professional incompetence, or substandard care. If the entity does verify written notification was provided, all associated documentation must be obtained and incorporated into the credentialing and privileging file and VetPro. The practitioner must be afforded an opportunity to explain in writing, the circumstances leading to the agreement. STVHCS officials must evaluate the primary source information and the individual's explanation of the specific circumstances, documenting this review in the credentialing and privileging file and VetPro. ***NOTE:*** *It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the practitioner, requesting the State licensing board to disclose to VA all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint.*

(4) There may be instances where actions have been taken against an applicant's license for a clinically-diagnosed illness. Those applicants are eligible for appointment where they are acknowledged by the licensing, registering, or certifying entity as stable, the licensure action did not involve substandard care, professional misconduct, or professional incompetence, and the license, certificate, or registration is fully restored. A thorough analysis of the information obtained from the entity must be documented, signed by the appropriate reviewers and approving officials, and filed in the licensure section of the Credentialing and Privileging Folder.

(5) Exceptions to Licensure. Except as provided in VA Handbook 5005, Part II, Chapter 3, subparagraph 14b, all LIPs must have a full, active, current, and unrestricted license to practice in any State, Territory, or Commonwealth of the United States, or in the District of Columbia. The only exceptions provided in VA Handbook 5005 are:

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

(b) An individual who has been granted an institutional license by the State which permits faculty appointment and full, unrestricted clinical practice at a specified educational institution and its affiliates, including STVHCS; or, an institutional license which permits full, unrestricted clinical practice at STVHCS. This exception is only used to appoint an individual who is a well-qualified, recognized expert in the individual's field, such as a visiting scholar, clinician, and/or research scientist, and only under authority of 38 U.S.C. 7405. It may not be used to appoint an individual whose institutional license is based on action taken by a SLB.

(c) An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a time-limited or temporary State license

or permit pending a meeting of the SLB to give final approval to the candidate's request for licensure. The license must be active, current, and permit a full, unrestricted practice. Appointments of health care professionals with such licenses must be made under the authority of 38 U.S.C. 7405 and are time-limited, not to exceed the expiration date of licensure.

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

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

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

(8) Physician applicants including physician residents who function outside of the scope of their training program, i.e., who are appointed as Admitting Officer of the Day, must be screened with the FSMB through VetPro prior to appointment. If additional information is needed from the practitioner in response to this information, that must be obtained through, and documented in VetPro.

(9) Appointment of Candidates with Previous or Current Adverse Action Involving Licensure. Physicians and dentists, or other licensed practitioners who have had a license or licenses restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, may be appointed under the appointment procedures that apply to other physicians, dentists, or other health professionals in accordance with VHA Directive 1100.19.

h. **Drug Enforcement Agency (DEA) Certification**

NOTE: *Where a practitioner's State of licensure requires individual DEA certification in order to be authorized to prescribe controlled substances, the practitioner may not be granted prescriptive authority for controlled substances without such individual DEA certification.*

(1) Background. Physicians, dentists, and certain other professional practitioners may apply for and be granted renewable certification by the Federal and/or State DEA, to prescribe controlled substances as part of their practice. Certification must be verified for individuals who claim on the application form to currently hold or to have previously held DEA certification. Individual certification by DEA is not required for VA practice, since practitioners may use the STVHCS's institutional DEA certificate with a suffix.

NOTE: *In order to prescribe controlled substances, contract licensed health care professionals who practice outside VA facilities must possess individual DEA registration in the State of practice. In order to obtain such individual DEA registration in the State of practice, the practitioner needs to be licensed by that State. However, contract licensed health care professionals who are practicing within VA facilities may rely on the STVHCS's institutional DEA certification with a sufix.*

(2) Application. Each applicant possessing a DEA certificate must document information about the current or most recent DEA certificate on the appropriate VA application form. Any applicant whose DEA certification (Federal and/or State) has ever been revoked, suspended, limited, restricted in any way, or voluntarily or involuntarily relinquished, or not renewed, is required to furnish a written explanation at the time of filing the application and at the time of reappraisal.

(3) Restricted Certificates. A State agency may obtain a voluntary agreement from an individual not to apply for renewal of certification, or may decide to disapprove the individual's application for renewal as a part of the disciplinary action taken in connection with the individual's professional practice. While there are a

number of reasons a license may be restricted which are unrelated to DEA certification, an individual's State license is considered restricted or impaired for purposes of VA practice if a SLB has:

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

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

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

NOTE: For new appointments after a break in service, any Federal or State DEA certification active at the time of separation must be verified, and any change in status documented.

i. **Employment Histories and Pre-employment References.** For practitioners requesting clinical privileges, at least three references must be obtained, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges.

(1) For any candidate whose most recent employment has been private practice for whom employment histories may be difficult to obtain, STVHCS officials must contact any institution(s) where clinical privileges are and/or were held, professional organizations, references listed on the application form, and/or other agencies, institutions, or persons who would have reason to know the individual's professional qualifications.

(2) For applicants requesting clinical privileges, the STVHCS needs to send a minimum of two requests to verify that the practitioner's currently held or most recently held clinical privileges are (or were) in good standing with no adverse actions or reductions for the specified period. For those health care professionals who have recently completed a training program, one reference needs to be from the Program Director attesting to the individual's competency and skill. ***NOTE:*** *Ideally, references need to be from authoritative sources, which may require that STVHCS officials obtain information from sources other than the references listed by the applicant.*

(3) As appropriate to the occupation for which the applicant is being considered, references need to contain specific information about the individual's scope of practice and level of performance. For example, information on:

(a) The number and types of procedures performed, range of cases managed, appropriateness of care offered, outcomes of care provided, etc.

(b) The applicant's medical and clinical knowledge, interpersonal skills, communication, clinical judgment, technical skills, and professionalism as reflected in results of quality improvement activities, peer review, and/or references, as appropriate.

(c) The applicant's health status in relation to proposed duties of the position and, if applicable, to clinical privileges being requested.

j. **Health Status.** All applicants and employees, regardless of type of appointment, must have a new appointment after a break in service. They are required to declare on the appropriate health status form that there are no physical or mental health conditions that would adversely affect ones ability to carry out requested responsibilities. This requirement also applies to all who are required to be credentialed in accordance with this policy. This declaration of health must be confirmed by a physician designated by, or acceptable to, the STVHCS, such as the employee health physician or physician supervisor from the individual's previous employment. Confirmation, at a minimum, is to be in the form of a countersignature by the confirming physician. The confirming physician may not be related to the applicant by blood or marriage.

k. Malpractice Considerations

(1) Applicants. VA application forms, or supplemental forms, require applicants to give detailed written explanations of any involvement in administrative, professional, or judicial proceedings, including Federal tort claims proceedings, in which malpractice is, or was, alleged. If an applicant has been involved in such proceedings, a full evaluation of the circumstances must be made by officials participating in the credentialing, selection, and approval processes prior to making any recommendation or decision on the candidate's suitability for VA appointment.

(2) Employees and Other Returning Practitioners. At the time of initial hire, a new appointment after a break in service, or reappraisal, each employee or returning practitioner (e.g., contractor) is asked to list any

involvement in administrative, professional, or judicial proceedings, including Tort claims, and to provide a written explanation of the circumstances, or change in status. A review of clinical privileges, as appropriate, must be initiated if clinical competence issues are involved.
(3) Primary Source Information. Efforts should be made to obtain primary source information regarding the issues involved and the facts of the cases. The Credentialing and Privileging folder must contain an explanatory statement by the practitioner and evidence that the STVHCS evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication by an insurance company, court of jurisdiction, or statement of claim status from the attorney. A good faith effort to obtain this information must be documented by a copy of the refusal letter or report of contact.
(4) Evaluation of Circumstances. STVHCS evaluating officials must consider VA's obligation as a health care provider to exercise reasonable care in determining that health care professionals are properly qualified, recognizing that many allegations of malpractice are proven groundless.
(a) STVHCS officials must evaluate the individual's explanation of specific circumstances in conjunction with the primary source information related to the payment in each case. The practitioner's explanatory statement is to be documented in the Supplemental Questions. A practitioner's statement included in the NPDB-HIPDB report does not satisfy the need for the practitioner to provide an explanation. This information is considered a secondary source and does not meet the standard of primary source verification. Primary source verification must be obtained on this information from the appropriate sources.

l. NPDB – HIPDB Screening
(1) Proper screening through the NPDB-HIPDB is required for applicants, including: physician residents who function outside of the scope of their training program, i.e., those appointed as Admitting Officer of the Day; all members of the Medical Staff and other health care professionals who hold clinical privileges, who are, or have ever been, licensed to practice their profession or occupation in any job title represented in the NPDB and HIPDB Guidebooks; or who are required to be credentialed in accordance with this policy. NPDB-HIPDB screening is required prior to appointment, including reappointment and transfer from another VA facilities, whether or not VA requires licensure for appointment, reappointment, or transfer. This screening must be accomplished by enrolling the practitioner in the NPDB-HIPDB PDS. The NPDB-HIPDB PDS provides ongoing monitoring of health care practitioners.
(2) These procedures apply to all the VHA physicians, dentists, and other health care practitioners who are appointed to the Medical Staff or who hold clinical privileges whether utilized on a full-time, part-time, intermittent, consultant, attending, WOC, on-station fee-basis, on-station scarce medical specialty contract, or on-station sharing agreement basis.
(3) The Director is the authorized representative who authorizes all submissions to the NPDB-HIPDB. Any delegation of that authority to other STVHCS officials is to be documented, in writing, to include date of delegation, circumstances governing delegation, and title (not name) of the official who may make requests.

m. Appointment and Termination of Employment under Title 5 and Title 38 Staff Relative to NPDB-HIPDB Screening
(1) If the NPDB-HIPDB screen through enrollment in the NPDB-HIPDB PDS shows action against clinical privileges, adverse action regarding professional society membership, medical malpractice payment for the benefit of the practitioner, or Federal health care program exclusion, STVHCS officials must verify that the practitioner fully disclosed all related information required and requested by VA in its pre-employment, credentialing, and/or clinical privileging procedures.
(2) The practitioner may be employed or continued in employment only after applicable procedural requirements are met.
(3) Following are the types of reports that a STVHCS might receive and the action, or source of guidance for action, to be used in each case.
(a) Reviews conducted subsequent to NPDB-HIPDB reports are to be thoroughly documented in the credentialing and privileging record (electronic and paper). Reviews include, but are not limited to, the Service Chief's as well as the preliminary review of the CEB of the Medical Staff and could result in a decision to recommend:

1. Appointment, or continue in an appointed status with no change in originally anticipated action.
2. Appointment, or continue appointment status with changes, including, but not limited to, modification of clinical privileges or provision of training.
3. Non-appointment or termination.
(b) In order to ensure an appropriate review is completed in the credentialing process, a higher-level review must be performed by the VISN CMO to ensure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO review must be completed prior to presentation to the CEB of the Medical Staff, for review and recommendation to continue the appointment and privileging process.
1. Circumstances requiring review by the VISN CMO are:
a. Three or more medical malpractice payments in payment history,
b. A single medical malpractice payment of $550,000 or more, or
c. Two medical malpractice payments totaling $1,000,000 or more
NOTE: *This second level review is in no way an indication that practitioners who meet these criteria are more likely to have clinical practice issues.*
2. The VISN CMO, in this oversight role, may request additional information as to the specific circumstance of the report or STVHCS's review process. The VISN CMO review must be documented on the Service Chief's Approval screen in VetPro as an additional entry recommending appointment in these cases. Once requirements for consideration and evaluation of any action reported by NPDBHIPDB have been completed, the appointment or continued appointment decision, if appropriate, must be made following guidance in VHA Handbook 1100.19; Title 5 policies and procedures specified in Title 5 Code of Federal Regulations (CFR) 315, 731, or 752; Federal or VA acquisition regulations; VA Directive and Handbook 0710; and VA Directive and Handbook 5021, as they apply to the category of practitioner.

n. **Credentialing for Telehealth and Teleconsultation.** When the staff of a STVHCS determines that telemedicine and/or teleconsultation is in the best interest of quality patient care, appropriate credentialing and privileging is required.
(a) All practitioners treating patients using telemedicine and teleconsultation must be qualified to deliver the required level of consultation, care, and treatment
(b) The practitioner providing the telemedicine and/or teleconsultation services must be credentialed and privileged in accordance with this policy.
(1) Teleconsultation. The practitioner providing only teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located when providing teleconsultation services.
(a) These practitioner's credentials must be shared with the facility receiving the teleconsultation services using shared access of the VetPro file.
(b) With the exception of the separate NPDB-HIPDB query, the practitioner providing teleconsultation services does not have to be separately appointed or credentialed at the facility or site where the patient is physically located.
(c) When the practitioner provides only teleconsultation by offering advice that supports care provided by the on-site licensed independent privileged provider, a copy of the practitioner's current clinical privileges must be made available to the facility or site where the patient is physically located. The practitioner providing teleconsultation services does not have to be separately privileged at the facility or site where the patient is physically located.
(2) Telemedicine. When telemedicine services are being provided by the practitioner who directs, diagnoses, or otherwise provides clinical treatment (i.e., teleradiology, teledermatology, etc.) to a patient using a telemedicine link, the practitioner must be appointed, credentialed, and privileged at the facility which receives the telemedicine services (patient site), as well as at the site providing the services.
NOTE: *Telemedicine involves the use of technology and is therefore a modality for the delivery of existing clinical practices. As such, there are no separate or distinct privileges for telemedicine. When considering the granting of privileges at the facility where the practitioner is physically based, the general privileging process needs to include the appropriateness of using telemedicine to deliver services and this site is*

considered a separate site of care in the establishment of privileges. Any consideration concerning the appropriate utilization of telemedicine equipment by the practitioner needs to be considered as part of the privileging process by the facility where the practitioner is physically located.

(3) Contracts for Telemedicine and/or Teleconsultation Services. Contracts for telemedicine and/or teleconsultation services need to require that these services be performed by appropriately-licensed individuals. Unless otherwise required by the specific contract or Federal law (such as the Federal Controlled Substances Act), contract health care professionals must meet the same licensure requirements imposed on VA employees in the same profession whether they are on VA (Federal) property or not when providing telemedicine or teleconsultation services.

NOTE: *Some states do not allow telemedicine and/or teleconsultation across state lines, unless the provider is licensed in the state where the patient is physically located. In these states, the clinical indemnity coverage of contract practitioners may be void, even if they are credentialed and privileged by VA. Prior to the commencement of services by the contract practitioners providing telemedicine and/or teleconsultation or remotely monitoring physiology data from veteran patients, the State regulatory agency in the state in which the practitioner is physically located as well as the state where the patient is physically located, must be consulted. When dealing with Federal entities, additional licenses that authorize the provision of telemedicine and/or teleconsultation services in the relevant states may not be required. The opinion of the Regional Counsel needs to be sought in these matters.*

o. **Expedited Appointment to the Medical Staff.** There may be instances where expediting a medical staff appointment for LIPs is in the best interest of quality patient care. The application must be a "clean" application with no current or previously successful challenges to licensure; no history of involuntary termination of medical staff membership at another organization; no voluntary limitation, reduction, denial, or loss of clinical privileges; and no final judgment adverse to the applicant in a professional liability action.

(1) The credentialing process for the Expedited Appointment to the Medical Staff cannot begin until the LIP completes the credentials package, including but not limited to a complete application; therefore, the provider must submit this information through VetPro and documentation of credentials must be retained in VetPro.

(2) Credentialing requirements for this process must include confirmation of:

a. The physician's education and training (which, if necessary, can be accomplished in 24 hours through the purchase of the American Medical Association's Physician Profile);

b. One active, current, unrestricted license verified by the primary source State, Territory, or Commonwealth of the United States or in the District of Columbia;

NOTE: *To be eligible for appointment, a practitioner must meet current legal requirements for licensure (see 38 U.S. C. § § 7402(b) and (f), and preceding subpar. 5g).*

c. Confirmation on the declaration of health, by a physician designated by or acceptable to the STVHCS, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;

d. Query of licensure history through the FSMB Action Data Center with no report documented;

e. Confirmation from two peer references who are knowledgeable of and confirm the physician's competence, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges, or who would have reason to know the individual's professional qualifications.

f. Current comparable privileges held in another institution; and

g. NPDB-HIPDB PDS registration with documentation of no match.

(3) If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted; and there is no history of malpractice payment, a delegated subcommittee of the CEB of the Medical Staff, consisting of at least two members of the full committee, may recommend appointment to the Medical Staff. Full credentialing must be completed within 60 calendar days and presented to the CEB of the Medical Staff for ratification.

(4) The expedited appointment process may only be used for what are considered "clean" applications. The expedited appointment process can not be used:

(a) If the application is not complete (including answers to Supplemental Questions, Declaration of Health, and Bylaws Attestation); or

(b) If there are current or previously successful challenges to licensure; or

(c) If there is any history of involuntary termination of medical staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges; or

(d) If there has been a final judgment adverse to the applicant in a professional liability action.

(5) This recommendation by the delegated subcommittee of the CEB of the Medical Staff must be acted upon by the Director. The 60 calendar days for the completion of the full credentialing process begins with the date of the Director's signature.

(6) This is a one-time appointment process for initial appointment to the Medical Staff. The effective date of appointment is the date that the expedited appointment is signed by the Director, even though ratification of the appointment is accomplished within 60 calendar days (the effective date does not change).

p. **Temporary Medical Staff Appointments for Urgent Patient Care Needs.**

NOTE: *Temporary appointments for urgent patient care needs may not exceed 60 days.*

(1) Temporary medical staff appointment and privileges may be granted for urgent patient care needs. Examples include:

(a) A situation where a physician becomes ill, takes a leave of absence, or resigns appointment and a physician would need to cover that physician's practice.

(b) A situation where a specific LIP with specific skill is needed to augment the care to a patient that the patient's current privileged LIP does not possess.

(2) When there is an emergent or urgent patient care need, a temporary appointment may be made, in accordance with VA Handbook 5005, Part II, by the STVHCS Director prior to receipt of references or verification of other information and action by a Professional Standards Board. Minimum required evidence includes:

(a) Verification of at least one, active, current, unrestricted license with no previous or pending actions;

(b) Confirmation of current comparable clinical privileges;

(c) Response from NPDB-HIPDB PDS registration with no match;

(d) Response from FSMB with no reports;

(e) Receipt of at least one peer reference who is knowledgeable of and confirms the provider's competence, and who has reason to know the individual's professional qualifications; and

(f) Documentation by the STVHCS Director of the specific patient care situation that warranted such an appointment.

(3) An application through VetPro must be completed within 3 calendar days of the date the appointment is effective. This includes Supplemental Questions, a Declaration of Health, and a Release of Information.

(4) If the Temporary appointment is not converted to another form of medical staff appointment, complete credentialing must be completed, even if completion occurs after the practitioner's temporary appointment is terminated or expires. If unfavorable information is discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

q. **Reappraisal.** Reappraisal is the process of evaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the STVHCS. The reappraisal process must include: the practitioner's statements regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction or loss of privileges at another hospital; loss of medical staff membership; pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment; mental and physical status; and any other reasonable indicators of continuing qualification and competency. Additional information regarding current and/or changes in licensure and/or registration status (primary source verification is required at the time of expiration of the license and at the time of reappointment); NPDBHIPDB PDS registration and report results; peer recommendations; continuing medical education and continuing education units; and verification regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review. ***NOTE:***

Information from VA Form 10-2623, Proficiency Report, or VA Form 3482b, Performance Appraisal, may be used.

(1) Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and informing the Director, or designee of any changes in the status of these credentials at the earliest date after notification is received by the individual. At the time of expiration of any license, and at the time of reappraisal, prior to reappointment, the practitioner must provide a signed release of information VA Form 10-0459 which authorizes the primary source to provide VA with written verification of requested information and to disclose information concerning each lawsuit, civil action, or other claim brought against the practitioner for malpractice or negligence; each disciplinary action taken or under consideration; any open or previously concluded investigations; any changes in the status of the license; and all supporting documentation related to the information provided.

(2) If at any time, after the initial appointment, it is noted that a provider has a license revoked for substandard care, professional misconduct, or professional incompetence, immediate consultation with the Regional Counsel is required in order to ensure the practitioner meets current legal requirements for licensure (see 38 U.S.C. §§ 7402(b) and (f) and subpar. 5g).

(3) For credentials that were held previously, but are no longer held or are no longer full and unrestricted, the practitioner must be asked to provide a written explanation of the reason(s). The verifying official must contact the SLB(s) or issuing organization(s) to verify the reason(s) for any change.

r. Transfer of Credentials. When practitioners are assigned to more than one health care facility for clinical practice, the "primary" or originating facility must convey all relevant credentials information to the gaining or satellite facility in accordance with VHA Handbook 1100.19.

s. Disposition of Credentialing and Privileging Files. Disposition of Credentialing and Privileging files will be managed in accordance with VHA Handbook 1100.19.

6. PRIVILEGING

NOTE: *Paragraph 6 contains the administrative and clinical requirements and procedures relating to the granting of clinical privileges, reappraisal, and re-privileging, and reduction and revocation of privileges.*

a. **Provisions**

(1) Privileges are granted within STVHCS site and scope of the STVHCS mission.

(2) Only practitioners who are licensed and permitted by law and STVHCS to practice independently may be granted clinical privileges.

(3) Clinical privileging is the process by which the institution grants the practitioner permission to independently provide specified medical or other patient care services, within the scope of the practitioner's license and/or an individual's clinical competence, as determined by peer references, professional experience, health status (as it relates to the individual's ability to perform the requested clinical privileges), education, training, and licensure and registration.

b. Review of Clinical Privileges. Applicants completing application forms are required to respond to questions concerning clinical privileges at VA and non-VA facilities. A minimum of two efforts to obtain verification of clinical privileges currently, or most recently, held at other institutions is to be made and documented in writing in the Credentialing and Privileging folder. That verification needs to indicate whether the privileges are (or were) in good standing with no adverse actions or reductions for the specified period of time.

c. Procedures. Clinical privileges are granted for a period not to exceed 2 years. Clinical privileges are not to be extended beyond the 2-year period, which begins from the date the privileges are approved by the Director. However, clinical privileges granted to contractors may not extend beyond the contract period. Each new contract period requires reappraisal and re-privileging.

(1) General Criteria**.** General criteria for privileging must be uniformly applied to all applicants.
(a) Such criteria must include, at least:
1. Evidence of current licensure;
2. Relevant training and/or experience;
3. Current competence, and health status (as it relates to the individual's ability to perform the requested clinical privileges); and
4. Consideration of any information related to medical malpractice allegations or judgments, loss of medical staff membership, loss and/or reduction of clinical privileges, or challenges to licensure.
(b) Each service chief must establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and STVHCS. Clinical privileges must be based on evidence of an individual's current competence. When privilege delineation is based primarily on experience, the individual's credentials record must reflect that experience, and the documentation must include the numbers, types, and outcomes of related cases.
(2) Delineation of Privileges. Delineated clinical privileges are an accurate, detailed, and specific description of the scope and content of patient care services for which a practitioner is qualified; they are based on credentials and performance and are authorized by STVHCS.
(a) Privileges granted to an applicant are STVHCS specific and are based on the procedures and types of services that are provided. The requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same.
(b) Service Chiefs develop Service Specific privileges by analysis of risk categories to produce a list of procedures by specialties and/or Service area. The privileges are reviewed by the PSB, CEB, and approved by the Director. Development of privileges considers any combination of: level of training and experience, patient risk categories, and lists of procedures or treatments. The criteria for the delineation of privileges will be reviewed by the PSB annually.
(3) Service Specific Privileges. Each practitioner must be assigned to, and have clinical privileges in, one clinical service and may be granted privileges in other clinical services. The exercise of clinical privileges within any service is subject to the policies and procedures of the service and the authority of the service chief.
(4) Setting Specific Privileges. Privileges are setting specific requiring consideration of each unique setting's characteristics, such as: adequate facilities, equipment, and number and type of qualified support personnel and resources. Setting-specific privileges are granted based on the practitioner's qualifications, and on consideration of the procedures and types of care, treatment, and services that can be performed or provided within the proposed setting.

d. **Initial Privileges.** Clinical privileges must be granted for all physicians, dentists, and other health care professionals licensed for independent practice. The process for the requesting and granting of clinical privileges follows:
(1) Clinical privilege requests must be initiated by the practitioner. For all practitioners desiring clinical privileges, the initial application for appointment must be accompanied by a separate request for the specific clinical privileges desired by the applicant. The applicant has the responsibility to establish possession of the appropriate qualifications, and the clinical competency to justify the clinical privileges request.
(2) The applicant's request for clinical privileges, as well as all credentials offered to support the requested privileges, must be provided for review to the service chief responsible for that particular specialty area. The service chief must review all credentialing information including health status (as it relates to the ability to perform the requested clinical privileges), experience, training, clinical competence, judgment, clinical and technical skills, professional references, conclusions from performance improvement activities that are not protected under 38 U.S.C 5705 , and any other appropriate information. Upon review of credentialing documents, the Service chief makes a recommendation, in VetPro, as to the practitioners clinical request for privileges.
NOTE: The Service Chief and/or Acting Service Chief's Approval must be completed by the service chief and no portion of this process may be delegated, including documentation in VetPro.

(3) Subsequent to the service chief's review and recommendation, the request for privileges, along with the appointment recommendation of the Professional Standards Board (PSB) or credentialing committee (if applicable), must be submitted to the Medical Staff's CEB for review. The Medical Staff's CEB evaluates the applicant's credentials to determine if clinical competence is adequately demonstrated to support the granting of the requested privileges. Minutes must reflect the documents reviewed and the rationale for the stated conclusion. A final recommendation is then submitted to the Director.

(4) Residents who are appointed, outside of their training program, to work on a fee basis as Admitting Officer of the Day must be licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program, and must meet the same requirements as all physicians and dentists appointed at the STVHCS. The term "resident" includes health care professionals in advanced PG education programs who are typically referred to as "fellows."

(5) Copies of current clinical privileges must be available to hospital staff on a need-to-know basis in order to ensure providers are functioning within the scope of their clinical privileges. Operating rooms and intensive care units are examples of areas where staff must be aware of provider privileges. Copies of privileges may be given to individuals on a need-to-know basis (e.g., a service chief responsible for monitoring compliance with the privileges granted, or a pharmacist who verifies prescribing privileges or establishes limitations on prescribing for certain medical staff members). The mechanism is to be concurrent with the exercise of privileges, not retrospective.

NOTE: *Practitioners performing procedures outside the scope of their privileges may be subject to disciplinary or administrative action.*

(6) The requesting and granting of clinical privileges for COSs and STVHCS Directors must follow the procedures, as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant service chief responsible for the particular specialty area in which the COS or Director requests privileges. When considering clinical privileges for the COS an appropriate practitioner must chair the Medical Staff's CEB and the COS must be absent from the deliberations. The Medical Staff's CEB recommendation regarding approval of requested privileges is submitted directly to the STVHCS Director for action.

(7) The privileging of STVHCS COS and Director desiring clinical privileges must follow the procedures as outlined for new practitioners. The approval authority for the requested privileges is to be delegated to the Associate Director, who is authorized to act as Director for this purpose.

(8) In those instances where a VISN CMO or Director, or other staff not directly employed by the STVHCS (e.g., VA Central Office) is requesting clinical privileges, the process for such clinical privileges must follow the procedures, as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant service chief responsible for the particular specialty area. The Medical Staff's CEB recommendations regarding approval of requested privileges must be submitted directly to the Director for action.

(9) When a privileged practitioner is being considered for transfer, detail, or to serve as a consultant to another VA STVHCS, transfer of credentials are to be accomplished in accordance with VHA Handbook 1100.19. However, the practitioner must request privileges at STVHCS and provide the STVHCS with the required documentation.

(10) A denial of initial privileges, for whatever reason, is not reportable to the NPDB. Where it is determined, for whatever reason, that the initial application and request for clinical privileges should be denied, the credentialing file, and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the STVHCS Director. A "Do Not Appoint" screen must be completed in VetPro documenting the date of the decision (see subpar. 6h(1)).

e. Temporary Privileges for Urgent Patient Care Needs. Temporary privileges for health care professionals in the event of emergent or urgent patient care needs may be granted by the Director at the time of a temporary appointment. Such privileges must be based on documentation of a current State license and other reasonable, reliable information concerning training and current competence. The recommendation for temporary privileges must be made by the COS and approved by the Director.

Temporary privileges are not to exceed 60 calendar days. (See Temporary Medical Staff Appointments for Urgent Patient Care Needs for further instruction.)

f. Disaster Privileges. Internal/External Disaster privileges may be granted when the emergency management plan has been activated, and STVHCS is unable to handle the immediate patient needs. The process for granting disaster privileges will follow the structure of the Hospital Incident Command System (HICS):

(1) Volunteers will be screened through Volunteer Service according to focus of volunteer ability and activity such as clinical or labor pool;

(2) Clinical volunteer providers i.e. physician, dentist, psychologist, physician assistant, nurse practitioner will be directed to the Medical Staff Unit Leader (under the Planning Chief) for further clearance;

(3) The Medical Staff Unit Leader or designee will ensure volunteer practitioners must at a minimum present a valid photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

(a) A current hospital picture identification card that clearly identifies professional designation.

(b) A current licensure, certification or registration.

(c) Primary Source verification of licensure, certification or registration if required by law and regulation to practice a profession.

(d) Identification indication that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group.

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

(f) Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

(4) The Medical Staff Unit Leader or designee will escort the provider volunteer to the Operations Chief;

(5) The Operations Chief under the HICS is responsible to the Incident Commander for the management and assignment of disaster responsibilities and all clinical care related to the emergency as well as ensuring the safe and continuing care of patients already in the facility. The Operations Chief is responsible for ensuring that volunteering practitioners are appropriately assigned to practice oversight by an LIP through direct observation, mentoring, or medical review. The Operations Chief or designee will identify and assign appropriate disaster responsibilities, clinical duties and practice oversight for all volunteer practitioners;

(6) Assignments may be approved by the Incident Commander upon recommendation by the Operations Chief (Chief of Staff or designee). At the time of assignment, the Medical Staff Unit Leader or designee will ensure that volunteer practitioners will be given a name identification badge that clearly identifies them as a volunteer practitioner.

(7) Within 72 hours related to the continuation of disaster responsibilities initially assigned, the operations Chief must make a recommendation through the Incident Commander or the Associate Director for Patient Care Services to the Director on whether to continue with the disaster responsibilities initially assigned. This recommendation should be made from the information gathered during the verification of licensure and/or credentialing process. Information obtained from directive observation, mentoring and medical record review may also be considered in making the determination to continue disaster assignments.

(8) Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer provider presented him/herself to the facility, whichever comes first. If primary source verification of a volunteer provider's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

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

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

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

(9) Disaster privileges may not exceed 10 calendar days or the length of the declared disaster, whichever is shorter. At the end of this period the practitioner needs to be converted to Temporary Privileges defined by this policy or be relieved.
(10) Each Service will maintain and distribute to each staff member a recall list for emergency response. Each licensed independent employee will report to his/her area of work and supervisor or designee in the event of an emergency. If the work area and/or supervisor or designee is not accessible, the employee will report to the Medical Staff Unit Leader for further instruction. Each licensed independent employee will function within their current clinical role and approved privileges, unless instructed otherwise by their supervisor or the Operations Chief (Chief of Staff or designee).

g. **Focused Professional Practice Evaluation.** This is a process whereby the STVHCS evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of STVHCS.
(1) This is a time-limited period during which the Medical Staff leadership evaluates and determines the practitioner's professional performance.
(2) Consideration for the focused professional practice evaluation is to occur at the time of initial appointment to the Medical Staff, or the granting of new, additional privileges. The focused professional practice evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.
NOTE: *The Focused Professional Practice Evaluation is not a restriction or limitation on the practitioner to independently practice, but rather an oversight process to be employed by the STVHCS when a practitioner does not have the documented evidence of competent performance of the privileges requested.*
(3) The criteria and procedures for the focused professional practice evaluation process are described in MCPM 11-08-54, Focused Professional Practice Evaluation.
NOTE: *Failure of a practitioner to accept the criteria for the focused professional practice evaluation will result in new privileges not being granted or additional actions taken as appropriate, for currently privileged providers.*
(4) Results of the Focused Professional Practice Evaluation must be documented in the practitioner's provider profile and reported to the CEB of the Medical Staff for consideration in making the recommendation on privileges and other considerations.

h. **On-Going Monitoring of Privileges.** This allows STVHCS to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the Medical Staff leadership. The criteria and procedures for the focused professional practice evaluation process are described in MCPM 11-08-58, Evidence-Based Professional Practice Evaluation for Privileging, Maintaining Privileges and Reprivileging.

i. **Reappraisal and Re-privileging**
(1) Reappraisal. Reappraisal is the process of reevaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within STVHCS.
(a) Reappraisal for the granting of clinical privileges must be conducted for each practitioner at least every 2 years. However, reappraisal may be required more frequently for contractors, depending upon the length of the contract period.
1. The reappraisal process must include:
a. The practitioner's statements regarding successful or pending challenges to any licensure or registration;
b. Voluntary or involuntary relinquishment of licensure or registration;
c. Limitation, reduction, or loss (voluntary or involuntary) of privileges at another hospital;
d. Loss of medical staff membership;
e. Pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment;

f. Mental and physical status (as it relates to the ability to perform the requested clinical privileges);
g. Relevant practitioner specific data as compared to aggregate data when available;
h. Morbidity and mortality data when available; and
i. Any other reasonable indicators of continuing qualifications.

NOTE: *If there is evidence of pending malpractice cases or malpractice cases closed since last reappraisal or initial appointment, every effort must be made and documented to obtain relevant information regarding the issues involved and the facts of the case(s). The Credentialing and Privileging folder must contain an explanatory statement by the practitioner and evidence thatSTVHCS evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication from the primary source to include, but not limited to: an insurance company, court of jurisdiction, or statement of claim status from the attorney. In the case of the Federal Tort Claims Act (FTCA), information on the adjudication of the case may come from the STVHCS Risk Manager, the Regional Counsel, or the Office of Medical-Legal Affairs.*

NOTE: *If there is evidence of voluntary or involuntary relinquishment of licensure or registration (as applicable to the position), evidence must be obtained that the practitioner meets VA's licensure requirements (see 38 U.S.C. §§ 7402(b) and (f), and subpar. 5g).*

2. Additional information regarding licensure and/or registration status, NPDB-HIPDB PDS report results, peer recommendations, continuing medical education and continuing education unit accomplishments, and information regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review.

a. Peer references are best obtained from those of the same discipline or profession who practice with, and know the practitioner's practice. If possible at least one of the peer references needs to be obtained from someone of the same discipline or profession who can speak with authority on the practitioner's clinical judgment, technical skill, etc.

b. Where there is no one of the same discipline or profession with knowledge of the practitioner's practice, at least one peer reference must be obtained from a health care professional with essentially equal qualifications and comparable privileges with knowledge of the practitioner's performance and practice patterns. Careful consideration needs to be given to avoid the appearance of professional prejudice. A second peer reference can be obtained from a health care professional who has a referral relationship with the practitioner.

c. In instances where at least one peer reference cannot be obtained from a peer of the same profession or a professional with comparable privileges, assistance for the peer reference needs to be sought from the VISN CMO or VHA Program Director for the profession.

NOTE: *Information from VA Form 10-2623, or VA Form 3482b, may be considered.*

(b) Evaluation of professional performance, judgment, and clinical and/or technical competence and skills is to be based in part on results of provider-specific performance improvement activities.

(c) The reappraisal process should include consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in a practitioner's clinical practice.

(2) **Re-privileging.** Re-privileging is the process of granting privileges to a practitioner who currently holds privileges within STVHCS.

(a) This process must be conducted at least every 2 years. However, clinical privileges granted to contractors may not extend beyond the contract period.

(b) The service chief must assess a minimum of two peer recommendations and all other information that addresses the professional performance, judgment, clinical and/or technical skills, any disciplinary actions, challenges to licensure, loss of medical staff membership, changes in clinical privileges at another hospital, health status (as it relates to the ability to perform the requested clinical privileges), and involvement in any malpractice actions. The service chief must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending individual privileges and complete the "Service Chief's Approval" in VetPro. Upon completion of this assessment, the service chief makes a recommendation as to the practitioner's request for clinical privileges.

(c) The requested privileges and the service chief's recommendation must be presented, with the

supporting credentialing, health status, and clinical competence information, to the Medical Staff's CEB for review and recommendation. The decision of the Medical Staff's CEB must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and submitted to the Director, as the approving authority, for final action.

(d) Because STVHCS mission and clinical techniques change over time, it is normal that clinical privileges may also change. The service chief must review, with the practitioner, the specific procedures and/or treatments that are being requested. Issues, such as documented changes in the STVHCS mission, failure to perform operations and/or procedures in sufficient number, or frequency to maintain clinical competence in accordance with STVHCS established criteria, or failure to use privileges previously granted, will affect the service chief's recommendation for the granting of new privileges, or the granting of the continuation of privileges. These actions must be considered changes and are not to be construed as a reduction, restriction, loss, or revocation of clinical privileges. Such changes must be discussed between the service chief and the involved practitioner.

(e) Practitioners may submit a request for modification of clinical privileges at any time. Requests to increase privileges must be accompanied by the appropriate documentation, which supports the practitioner's assertion of competence, i.e., advanced educational or clinical practice program, clinical practice information from other institution(s), references, etc. The request must be made through VetPro by opening the electronic record for re-credentialing. In addition to verifying all current credentials and competency associated with this request, active licenses must be verified and a verification of the NPDB-HIPDB PDS reports must be made. Requests for other changes need to be accompanied by an explanatory statement(s). The request for modification of clinical privileges, supporting documents, and practitioner's Credentialing and Privileging folder must be presented to the appropriate service chief for review. The service chief considers the additional information and the entire Credentialing and Privileging folder before making a recommendation to the Medical Staff's CEB. The Medical Staff's CEB then presents a recommendation to the Director for action.

(f) The process of reappraisal and granting new clinical privileges for the Director and COS(s) is the same as outlined in preceding paragraphs. The Director's or COS's request for privileges must be reviewed, and a recommendation made by the relevant service chief responsible for the particular specialty area in which the privileges are requested. When the COS is being considered for privileging, the COS must be absent from the CEB of the Medical Staff deliberations, which an appropriate practitioner chairs. The Medical Staff's CEB recommendations related to the approval of the requested privileges must be submitted directly to the Director for action, or to the Associate Director who is authorized to act as Director for this purpose.

j. **Denial and Non-renewal of Privileges.** This paragraph defines policy and procedures related to the denial or non-renewal of clinical privileges and the requirements for reporting or not reporting such denials to the NPDB.

(1) At the time of initial application and request for clinical privileges, if it is determined for whatever reason that the application should be denied, the credentialing file and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the Director. A "Do Not Appoint" screen must be completed in VetPro documenting the date of this decision. This denial is not reportable to the NPDB.

(2) At the time of reappraisal and renewal of clinical privileges, privileges that are denied or not renewed based on STVHCS resources must be documented as such in the Credentialing and Privileging file, as well as the appropriate minutes. This action is not reportable to the NPDB.

(3) For all other actions in which clinical privileges requested by a practitioner are denied or not renewed, the reason for denial must be documented. If the reason for denial or non-renewal is based on, and considered to be related to, professional incompetence, professional misconduct, or substandard care, the action must be documented as such and is reportable to the NPDB after appropriate internal VA Medical Center due process procedures for reduction and revocation of privileges, pursuant to this Handbook, are provided (see VHA Handbook 1100.17).

NOTE: *VA only reports to the NPDB adverse privileging actions against physicians and dentists*

(see VHA Handbook 1100.17 and 38 CFR Part 46).

k. **Reduction and Revocation of Privileges.** This paragraph defines policy and procedures related to the reduction and/or revocation of clinical privileges based on deficiencies in professional performance.

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

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

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

(3) General Provisions

(a) These Activities may be separate from the Reappraisal and Re-privileging process. Data gathered in conjunction with STVHCS's performance improvement activity is an important tool for identifying potential deficiencies. Material that is obtained as part of a protected-performance improvement program (i.e., under 38 U.S.C. 5705), may not be used during the appraisal process, nor may any reduction or revocation of privileges action be based directly on such performance improvement data.

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

(b) Reduction and Revocation of Privileges. A reduction of privileges may include restricting or prohibiting performance of selected specific procedures, including prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically-disabling condition or further training in a particular area. Revocation of privileges refers to the permanent loss of clinical privileges.

(c) If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures indicated in this policy must be followed. Procedures for reduction and revocation of clinical privileges are identified in the following paragraphs, and apply to all practitioners included within the scope of this policy and VHA Handbook 1100.19.

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

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

(e) Adverse Professional Review Action. Any professional review action that adversely affects the clinical privileges of a practitioner for a period longer than 30 days, including the surrender of clinical

privileges or any voluntary restriction of such privileges, while the practitioner is under investigation, is reportable to the NPDB pursuant to the provisions of the VHA policy regarding NPDB reporting.

1. Summary Suspension. Clinical privileges may be summarily suspended when the failure to take such an action may result in an imminent danger to the health of any individual. Summary suspension pending comprehensive review and due process, as outlined in in this policy. However, the notice of summary suspension to the practitioner needs to include a notice that if a final action is taken, based on professional competence or professional conduct grounds, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. The notice of summary suspension needs to contain a notice to the individual of all due process rights.

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

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

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

2. Independent Contractors and/or Subcontractors

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

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

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

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

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

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

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

a. Such instances must be weighed against the potential for substandard care, professional misconduct, or

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

b. Under no circumstances should there be more than three automatic suspensions of privileges in 1 calendar year, and no more than 20 days per calendar year. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in a calendar year, a thorough assessment of the need for the practitioner's services needs to be performed and documented and appropriate action taken. Any action is to be reviewed against all reporting requirements.

(f) Procedures Applicable to Administrative Heads. Procedures to reduce and revoke clinical privileges identified within this Handbook are applicable to Directors, COSs, CMOs, and VISN Directors. All responsibilities normally assumed by the COS during the clinical privileging reduction or revocation process must be assigned to an appropriate practitioner who serves as acting chair of the Medical Staff's CEB. The COS may appeal the Director's decision, or the Director may appeal the Associate Director's decision, regarding the reduction of privileges decision to the VISN Director, just as all practitioners may appeal such a decision. A VISN Director whose clinical privileges to practice at a given STVHCS are reduced or revoked may appeal to the Chief VISN Officer.

(4) Reduction of Privileges

(b) Initially, the practitioner receives a written notice of the proposed changes in privileges from the COS, which notice must include a discussion of the reason(s) for the change. The notice also needs to indicate that if a reduction or revocation is effected based on the outcome of the proceedings, a report must be filed with the NPDB, with a copy to the appropriate SLBs in all states in which the practitioner holds a license, and in Texas. The notice must include a statement of the practitioner's right to be represented by an attorney or other representative of the practitioner's choice throughout the proceedings.

(c) The practitioner must be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the practitioner may respond in writing to the COS's written notice of intent. The practitioner must submit a response within 10 workdays of the COS's written notice. If requested by the practitioner, the COS may grant an extension for a brief period, normally not to exceed 10 additional workdays, except in extraordinary circumstances.

NOTE: *Prior to releasing any information to the practitioner or any other individual associated with the review, consultation with the STVHCS Privacy Officer or Regional Counsel is appropriate.*

(d) All information is forwarded to the Director for decision. The Director must make, and document, a decision on the basis of the record. If the practitioner disagrees with the Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 workdays after receipt of decision.

(d) The Director must appoint a review panel of three professionals, within 5 workdays after receipt of the practitioner's request for hearing, to conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges; any other review processes must be conducted on the basis of the record.

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

2. During such hearing, the practitioner has the right to:

a. Be present throughout the evidentiary proceedings.

b. Be represented by an attorney or other representative of the practitioner's choice.

NOTE: *If the practitioner is represented, this individual is allowed to act on behalf of the practitioner including questioning and cross-examination of witnesses.*

c. Cross-examine witnesses.

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

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

4. The panel must complete the review and submit the report within 15 workdays from the date of the close

of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause.
(e) The panel's report, including findings and recommendations, must be forwarded to the Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.
(f) The Director must issue a written decision within 10 workdays of the date of receipt of the panel's report. If the practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the Director constitutes a final action and the reduction is reportable to the NPDB.
(g) If the practitioner wishes to appeal the Director's decision, the practitioner may appeal to the appropriate VISN Director within 5 workdays of receipt of the Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.
(h) The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the practitioner's appeal.

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

(5) Revocation of Privileges

(a) Recommendations to revoke a practitioner's privileges must be made by the CEB of the Medical Staff, based upon review and deliberation of clinical performance and professional conduct information.

1. A revocation of privileges requires removal from both employment appointment and appointment to the Medical Staff, unless there is a basis to reassign the practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. An example could be the revocation of a surgeon's privileges for clinical practice issues, when reassignment to a non-surgical area is beneficial to meeting other needs of STVHCS.

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

NOTE: *Due process under all applicable policies and procedures must be afforded the practitioner.*

3. When revocation of privileges is proposed and not combined with a proposed demotion or dismissal, the due process procedures under reduction of privileges must pertain.

(b) In instances where revocation of privileges is proposed for permanent employees appointed under 3 8 U. S. C. 7401(1), the revocation proceedings must be combined with proposed action to discharge the employee under 38 U.S.C., Part V, Chapter 74, Subchapter V, or in accordance with current VA statutes, regulations, and policy.

NOTE: *In those instances where the permanent employee was appointed under 38 U.S. C. 7401(3), the revocation proceedings must be combined with proposed action to discharge the employee under VA Handbook 5021, Part 1, Employee/Management Relations, or current VA statutes, regulations, and policy.*

NOTE: *Practitioners, whose privileges are revoked for substandard care, professional incompetence, or professional misconduct, must be reported to the NPDB in accordance with the VHA policy on NPDB reporting. In addition, the practitioner's practice must be reviewed for reporting to SLB(s) consistent with VHA policy on SLB reporting.*

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

(6) Management Authority. Nothing in these procedures restricts the authority of management to temporarily detail or reassign a practitioner to non-patient care areas or activities, thus in effect suspending privileges while the proposed reduction of privileges or discharge, separation, or termination is pending.

(a) The Director, acting in the position of Governing Body as defined in the Medical Staff Bylaws, is the final authority for all privileging decisions. This decision must be based on the recommendations of the appropriate Service Chief(s), COS, and/or CEB of the Medical Staff.

(b) Furthermore, the Director, on the recommendation of the COS, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns.

(c) Nothing precludes VA from terminating a practitioner in accordance with VA Handbook 5021 procedures when the separation is not for a professional reason. Health care professionals appointed under authority of 38 U.S.C. 7405 may be terminated in accordance with VA Directive and Handbook 5021, when this is determined to be in the best interests of VA.

l. Inactivation of Privileges. The inactivation of privileges when a practitioner is not being an active member of the Medical Staff such as extended sick leave, or approved sabbatical. When providers return to the medical center following these circumstances, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be re-verified. Inactivation of privileges may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.

NOTE: *At the time of inactivation of privileges or separation, the Service Chief ensures that within 7 calendar days of the date of separation, the Provider Exit Review form is forwarded to the Medical Staff Office to validate that the practitioner met generally accepted standards of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.*

m. Deployment and/or Activation Privilege Status. In those instances where a provider is called to active duty, the provider's privileges are to be placed in a Deployment and/or Activation Status. The credential files continue to remain active with the privileges in this new status. If at all possible, this process for returning privileges to an active status must be communicated to providers before deployment.

(1) Providers returning from active duty must communicate with the appropriate supervisor as soon as possible upon returning to the area.

(2) The provider must update the electronic Credentials File after the file has been reopened for credentialing updating licensure information, health status, and professional activities while on active duty

(3) The credentials file must be brought to a verified status. If the provider performed clinical work while on active duty, an attempt must be made to confirm the type of duties, the provider's physical and mental ability to perform these duties, and the quality of the work; this information must be documented

(4) The verified credentials, the practitioner's request for returning the privileges to an active status, and the service chief's recommendation are to be presented to the Medical Staff's CEB for review and recommendation. The decision of the Medical Staff's CEB must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and forwarded to the Director for recommendation and approval of restoring the provider's privileges to Current and Active Status from Deployment and/or Activation Status

(5) In those instances when the practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges

(6) In those instances where the privileges lapsed during the call to active duty, the provider needs to provide additional references for verification and the medical center staff needs to perform all verifications required for reappointment

(7) In those instances where the provider was not providing clinical care while on active duty, the provider in cooperation with the Service Chief, Clinical Executive Board, and/or the CEB of the Medical

Center must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges needs to be initiated, on a short-term basis

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

(a) Verification of all licenses that were current at the time of deployment and/or activation as current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.

(b) Registration with the NPDB-HIPDB PDS with no match.

(c) A response from the FSMB with no match.

(d) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.

(e) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

NOTE: *No step in this process should be a barrier in preventing the provider from returning to the medical center in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.*

7. DOCUMENTATION OF THE MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

a. Upon completion of the verification of credentials, recommendations by the appropriate service chief and committee(s), and approval by the Director (acting as the Governing Body), the documentation of the appointment and granting of clinical privileges can be completed. Medical staff appointments and the granting of clinical privileges are to be entered in VetPro and the period may not exceed 2 years. There is no provision for any extension of appointments or privileges.

b. The appointment can be effective as of the date signed by the Director, but may not become effective at a date later than 30 calendar days from the date signed by the Director or 45 calendar days after the recommendation of the CEB of the Medical Staff, whichever is shorter.

c. Concurrent Appointments and Sharing of Files

(1) In those instances where a practitioner is providing care at more than one facility, including telemedicine services, medical staff appointments at all facilities need to be coordinated and concurrent.

(2) When the file is reopened for credentialing, each facility at which the provider holds a medical staff appointment needs to start the re-privileging process.

(3) Instructions to the provider need to clearly state that:

(d) The re-privileging process is going to be done concurrently at all facilities,

(e) The provider only needs to submit the renewal application in VetPro once, and

(f) The provider must attest to each STVHCS's Bylaws on the "Sign/Submit" screen.

(4) Each facility needs to consider sharing the practitioner's responses to the Supplemental Questions and the references submitted as part of this coordinated credentials process. In coordinating this effort, the credentialers need to determine who is going to request documentation of any items identified on the Supplemental, the references, and/or peer appraisals.

(5) A facility may not use any time-limited verifications that are obtained prior to the practitioner attesting to the STVHCS's Medical Staff Bylaws. Non-time limited information, such as education or training verification, may be used.

(6) Each facility needs to obtain the license verifications and document registration in the NPDB-HIPDB PDS.

(7) If at any point during the time a practitioner is shared, any of the facilities suspend the practitioner's privileges, or takes an action that is considered to be an adverse personnel, medical staff appointment, or privileging action, the facility taking the action must notify all facilities that share the provider of the action. This notification needs to be made to the COS of each facility for appropriate review and action

within the privileges granted at the shared facility.

d. **Conversion of Appointments with No Change in Privileges**

(1) In those instances where a provider has held a specific employment or medical staff appointment and is being converted to a different type of appointment, either medical staff appointment or Title 38 appointment, the practitioner must apply for this appointment.

(2) Prior to conversion all time-limited information must be verified, regardless of the period of time since previous verification.

(3) The NPDB-HIPDB PDS registration must be confirmed.

(4) The information obtained in this process must be evaluated and reviewed by the appropriate individuals in the same manner as initial appointments or reappraisal. This review must be documented in the appropriate minutes, as well as the credentialing and privileging folder and VetPro. The appointment date remains the same as the previous appointment with the expiration date not to exceed 2 years from that date.

8. REFERENCES: Title 38 U.S.C. 7304, 7401(1)(2)(3), 7402, 7405, 7409, and 7461 through 7464; Title 45 CFR Part 60; Public Laws (Pub. L.) 99-166 and 99-660 and its revisions; Pub. L. 100-177; Pub. L. 106-117, Section 209; Pub. L 105-33, Section 4331(c); Pub. L 104-191, Section 221; Title 3 8 CFR Part 46; Title 5 CFR Parts 315, 731, and 752; VA Handbook 5005; VA Handbook 5007; VA Directive and Handbook 5021; VA Handbook 6502.1; VHA Handbook 1100.19; The Joint Commission, Comprehensive Accreditation Manual for Hospitals; Privacy Act System of Records Notice for Healthcare Provider Records (77VA10Q).

RULES

SECTION R.1 GENERAL

R.1.1 The Rules relate to the role and/or responsibility of members of the Medical Staff with clinical privileges or scope of practice in the care of inpatients, outpatients, and emergency care patients as a whole or to specific groups as designated.

SECTION R.2 PATIENT RIGHTS (**See** Policy Memorandum 11-2009-67 or current version for further instruction.)

R.2.1 The treating physician will determine whether a patient is able to understand the Patient Rights and ensure that the treatment aspects of the patient's rights are fully protected.

R.2.2 Patients will be treated with respect and nondiscrimination:
(1) They will be treated with dignity, compassion and respect as individuals. Their privacy will be protected. They will receive care in a safe environment and one that supports the patient's positive self-image and dignity. STVHCS will seek to honor their cultural, spiritual, religious, individual and personal values, beliefs, and preferences.
(2) They, or someone they designate, have the right to keep and spend their own money.
(3) Treatment will respect their personal freedoms. Patients have the right to the least restrictive conditions necessary to achieve treatment purposes.
(4) As an inpatient or long-term care resident, they may wear their own clothes and keep personal items, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service.
(5) As an inpatient or long-term care resident, they have the right to social interaction, the opportunity for religious worship and spiritual support and regular exercise.
(6) As an inpatient or long-term care resident, they have the right to communicate freely and privately. They may have or refuse visitors and/or telephone calls.

R.2.3 Patients will receive information related to their care; health information will be kept confidential.
(1) They will be given information about the health benefits that they can receive. Information about the costs of care, if any, will be given to patients before they are treated.
(2) Medical records will be kept confidential. Information about patients will ***not*** be released without their consent unless authorized by law. Patients have the right to information in their medical record and may request a copy of the record. This will be provided except in rare situations where their VA physician feels the information will be harmful. In that situation, the patient has the right to have this discussed with their provider. Patients have the right to request amendment to the medical record and obtain information on disclosures of his or her health information, in accordance with law and regulation.
(4) They will be informed of all outcomes of care, including any injuries caused by their medical care. They will be informed about how to request compensation for injuries per STVHCS policy on Disclosure of Adverse Events.
(5) Information will be provided in a manner tailored to the patient's age, language and ability to understand.

R.2.4 Patients have the right to participate in treatment decisions.
(1) They, and any persons they choose, will be involved in all decisions about their care. They will be given information they can understand about the benefits and risks of treatment. They will be given other options. They can agree or refuse treatment. Refusing treatment will not affect their rights to future care but they have the responsibility to understand the possible

results to their health. If they believe they cannot follow the treatment plan, they have a responsibility to notify the treatment team.
(2) They have the right to communicate with those responsible for his/her care and receive from them adequate information concerning the nature and extent of his/her clinical problem, the planned course of treatment and the prognosis, be informed as to the nature and purpose of any medical treatment and/or technical procedures that are to be performed on him/her, 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 practitioner who is primarily responsible for his/her care, and to expect adequate instruction in self-care in the interim between visits to the medical center or to the practitioner;
(3) The name and professional title of the provider in charge of patient care will be provided, in writing. As a partner in the healthcare process, patients have the right to be involved in choosing their provider. They will be educated about their role and responsibilities as a patient. This includes their participation in decision-making and care at the end of life.
(4) They have the right to have their pain assessed and to receive treatment to manage their pain. They and their treatment team will develop a pain management plan together.
(5) They have the right to choose whether or not they will participate in any research project. Any research will be clearly identified. Potential risks of the research will be identified and there will be not pressure to participate.
(6) They will be involved in resolving any ethical issues about their care. They may consult with the Integrated Ethics Consultation Service, Integrated Ethics Council and/or other staff knowledgeable about health care ethics.
(7) Patients have the right to be free from neglect; exploitation (financial or other); verbal, mental, physical, and sexual abuse or harassment; physical punishment; retaliation and humiliation. Patients are encouraged and expected to seek help from their treatment team and/or a patient advocate if they have problems or complaints. They will be given understandable information about the complaint process. They may complain verbally or in writing, without fear of retaliation.
(8) The rights listed above apply to all individuals regardless of race, color, sex, sexual orientation, gender,identity, religion, disability, age, socioeconomic status, veteran status, ancestry, or national or ethnic origin.

SECTION R.3 INFORMED CONSENT FOR CLINICAL TREATMENTS AND PROCEDURES (See Policy Memorandum 11-10-67 or current version for further instruction.)

R.3.1 The practitioner who obtains the informed consent for the treatment or procedure must follow the processes outlined in policy. The practitioner who will perform the treatment or procedure must ensure that the informed consent was obtained, even when the practitioner performing the treatment or procedure is not the same practitioner who obtained the informed consent.

R.3.2 The signatures need not be witnessed, except when the patient's or surrogate's signature is indicated on the VA authorized consent form by an "X," in which case two adult witnesses (not including the practitioner) are required to sign the form. The signatures of these witnesses on the form attests only to the fact that the witnesses saw the patient or surrogate and the practitioner sign the form. ***NOTE:*** *If an individual cannot physically document consent, a member of the treatment team may sign on the patient's behalf and document the circumstances of the signature in a progress note. The signing health professional's signature must be witnessed by two adults.*

R.3.3 A properly-executed VA authorized consent form is valid for a period of 30 calendar days from the date signed. If during this 30-day period there is a significant change in the patient's condition that would reasonably be expected to alter the diagnosis or therapeutic decision, the consent is automatically rescinded and the informed consent process must be repeated for subsequent treatment.

R.3.4 A practitioner is defined as any physician, dentist, or health care professional granted specific clinical privileges to perform the treatment or procedure, including: (1) Medical and dental residents, regardless of whether they have been granted specific clinical privileges; and (2) Other health care professionals whose scope of practice agreement or other formal delineation of job responsibility specifically permits them to obtain informed consent, and who are appropriately trained and authorized to perform the procedure or to provide the treatment for which consent is being obtained.

R.3.5 For the purposes of documenting informed consent for clinical treatments and procedures that require signature consent, the VA-authorized consent form refers to the use of the iMedConsentTM software program to conduct the informed consent discussion, capture electronic signatures, and file the completed document electronically in the patient's record. Printed VA Form 10-431a, Consent for Clinical Treatment or Procedure and VA Form 10-431b, Consent for Transfusion of Blood Products is authorized for use if: (1) The patient declines to use the electronic signature pad, or (2) There is a temporary system failure that prohibits proper use of the iMedConsentTM software or hardware, or (3) The patient is giving consent by telephone or fax, or (4) The use of the equipment that supports the iMedConsentTM software program would introduce infection control issues.

R.3.6 All treatments and procedures require the prior, voluntary informed consent of the patient, or if the patient lacks decision-making capacity, the patient's authorized surrogate. Informed consent may be communicated either orally or in writing as follows:

R.3.6.1 Treatments and Procedures That Require Only Oral Informed Consent. Treatments and procedures that are low risk and within broadly-accepted standards of medical practice (e.g., administration of most drugs, vaccines, or minor procedures, such as routine X-rays) require oral informed consent, but do not require signature consent. In most cases, a brief statement such as "patient consented to treatment plan" is sufficient for these purposes.

R.3.6.2 Tests that provide information that is particularly sensitive or may have significant consequences for the patient require oral consent explicitly documented – that is, the test cannot be done unless the patient explicitly agrees – and there is also a specific requirement to document the patient's oral consent. Documentation of oral consent is required for tests to identify the following: Human Immunodeficiency Virus (HIV), illicit drug use, alcohol intoxication, Hepatitis C, Hepatitis B, Methicillin-Resistant Staphylococcus Aureus (MRSA), sexually transmitted diseases, and inheritable genetic abnormalities. A brief statement such as, "patient consents to [name of test]" is sufficient to satisfy the documentation requirement.

R.3.6.3 Treatments and Procedures That Require Signature Consent. Signature consent is required for treatments and procedures that: Can be reasonably expected to produce significant pain or discomfort to the patient; Can be reasonably expected to produce pain or discomfort to the patient that is substantial enough to require sedation, anesthesia, or narcotic analgesia; Can be reasonably considered to have a significant risk of complication or morbidity; Require injections of any substance into a joint space or body cavity (excluding the intravascular space); or are listed as follows:

1. Surgical or invasive procedures, including but not limited to: a. Any procedure done within an operating room; b. Acupuncture; c. Aspiration of body fluids or injection of therapeutic or diagnostic agents through the skin or into a body cavity (e.g., arthrocentesis, bone marrow aspiration, lumbar puncture, paracentesis, thoracentesis); d. Biopsy (e.g., breast, liver, muscle, kidney, genitourinary, prostate, bladder, skin); e. Cardiac procedures (e.g., cardiac catheterization, cardiac pacemaker electrode insertion, electrical cardioversion, stress tests to include exercise and pharmacologic methods); f. Central vascular access device insertion (e.g., arterial line, Swan-Ganz catheter, central venous line, peripherally inserted central catheter (PICC) line, Hickman catheter); g. Electrocautery; h. Endoscopy (e.g., bronchoscopy, colonoscopy, cystoscopy, laparoscopy); i. Interventional radiology

procedures (e.g., arthroplasty, angiography); j. Photocoagulation; k. Oral surgical procedures (including gingival biopsy);
2. Sterilization of reproductive capacity; m. Thoracostomy; n. Tracheostomy; and o. Transjugular intrahepatic portal stent (TIPS).
3. Sedation, other than anxiolysis (level one sedation).
4. Anesthesia, other than low risk local anesthesia (e.g., topical numbing agents).
5. Blood product transfusion.
6. Delivery of a child.
7. Laser Therapy.
8. Botox treatment for dystonia.
9. Dialysis (hemodialysis or peritoneal).
10. Electroconvulsive therapy.
11. Hazardous drugs (e.g., cancer chemotherapy, methadone for narcotic dependence, buprenorphine, thalidomide, clozapine, Retin A).
12. Photochemotherapy in combination with psoralens or other topical agents.
13. Lithotripsy.
14. High-risk imaging procedures where there is no other appropriate alternative diagnostic approach, such as: a. Intravascular injection of iodinated radiographic or gadolinium contrast agents in high-risk patients (e.g., those with prior allergic reactions, renal failure or other risk factors); c. Radionuclide therapy (e.g., radioiodine for hyperthyroidism and thyroid cancer, radiostrontium or adiosamarium for palliation of painful metastases to bone, Zevulin or Bexxar therapy for lymphoma or other radionuclide therapies); and d. Pregnant patient receiving intravascular contrast agents or x-radiation to the fetus.
15. Forensic Examination.

R.3.7 Determination of Decision-Making Capacity.

R.3.7.1 In order to obtain informed consent, the practitioner must first determine whether the patient has decision-making capacity. Patients are presumed to have decision-making capacity unless: an appropriate clinical evaluation determines that the patient lacks decision-making capacity, the patient is a minor, or the patient has been ruled incompetent by a court of law. The practitioner must perform(or obtain) and document a clinical assessment of decision-making capacity for any patient suspected of lacking decision-making capacity. If the practitioner determines that the patient is likely to regain decision-making capacity, the practitioner must wait until the patient's decision-making capacity returns, and then undertake the informed consent process with the patient, provided that delaying the recommended treatment or procedure would not adversely affect the patient's condition. If the practitioner determines that the patient is unlikely to regain decision-making capacity within a reasonable period of time, an authorized surrogate must be sought.

R.3.7.2 When the determination of lack of decision-making capacity is based on a diagnosis of mental illness, a psychiatrist or licensed psychologist must be consulted in order to ensure that the underlying cause of the lack of decision-making capacity is adequately addressed. However, even in this instance, the practitioner who will be performing the treatment or procedure remains responsible for the final determination of decision-making capacity with respect to informed consent for that treatment or procedure.

R.3.7.3 If the patient is considered a minor under State law in the jurisdiction where the VHA facility is located, that patient is deemed to lack decision-making capacity for giving informed consent except as otherwise provided by law. Consent must be obtained from the patient's parent or legal guardian.

R.3.7.4 Patients who have been judicially determined to be incompetent are incapable of giving consent as a matter of law. Such persons are deemed to lack decision-making capacity for the purpose of giving informed consent. If a practitioner believes that a patient who is legally incompetent does in fact have

the capacity to make a particular health care decision, the practitioner must discuss this with the legal guardian and seek advice from the local Integrated Ethics program or Regional Counsel.

R.3.8 Health Care Agent or Authorized Surrogate

R.3.8.1 Health Care Agent Is Authorized and Available: When a patient lacks decision making capacity, the practitioner must make a reasonable inquiry as to the availability and authority of an advance directive naming a Health Care Agent. A Health Care Agent has the highest priority as a surrogate.

R.3.8.2 No Health Care Agent Is Authorized and Available: The practitioner, with the assistance of other staff, must make a reasonable inquiry as to the availability of other possible surrogates according to the process described in current organizational policy on informed consent.

R.3.8.3 Surrogate Consent by Mail, Fax, or Telephone. See current STVHCS policy on informed consent for procedures. Signature consent by e-mail is not permitted.

R.3.9 Medical Emergencies.

R.3.9.1 In medical emergencies the practitioner may provide necessary medical care in emergency situations without the patient's or surrogate's express consent when all of the following conditions are met: (a) Immediate medical care is necessary to preserve life or avert serious impairment of the health of the patient or others; and (b) The patient is unable to consent; and (c) The patient has no surrogate, or the practitioner determines that waiting to obtain consent from the patient's surrogate would increase the hazard to the life or health of the patient or others.

R.3.9.2 In a medical emergency, reasonable attempts to contact the patient's surrogate must be made as promptly as possible, before or after treatment is begun, to explain the nature of the treatment or procedure, the indications, and the expected outcome. The patient's previously stated wishes (e.g., verbal, advance directive) must be followed to the extent that they are known and are applicable to the current situation. Whenever, due to the emergency exception, a treatment or procedure that requires signature consent has been provided without obtaining the patient's or surrogate's signature consent, the Service Chief must be notified and must review the record to verify that the emergency exception to obtaining signature consent has been appropriately applied. The Service Chief must document their review by either co-signing or writing an addendum to the progress note. See current STVHCS Informed Consent policy on process for medical record documentation and review when consent is not obtained due to the emergency exception.

R.3.10 Unusual or Extremely Hazardous Treatments and Procedures. No patient will undergo any treatment or procedure considered to be unusual or extremely hazardous, such as psychosurgery, except under extraordinary circumstances.

R.3.11 Consent for Disclosure of Title 38 United States Code (U.S.C.) Section 7332- Protected Information: VA-generated records that reveal the identity, diagnosis, prognosis, or treatment of VA patients related to drug abuse, alcoholism or alcohol abuse, infection with HIV infection, or sickle cell anemia must be kept confidential (including the fact that an HIV test was conducted or the positive or negative results of HIV testing). This information may not be released without the patient's special written consent, unless the disclosure is otherwise authorized by law.

R.3.12 Consent for Testing of a Source Patient after an Occupational Exposure. When such an occupational exposure occurs, optimal treatment for the employee may depend upon the source patient's medical condition(s). Testing to determine the source patient's medical condition(s) may only be performed

with the source patient's (or surrogate's) explicit informed consent and that consent must be obtained and documented according to procedures in current STVHCS Informed Consent policy.

R.3.13 Withholding or Withdrawal of Life-Sustaining Treatment. VA patients have the right to have unwanted life-sustaining treatment withheld or withdrawn even if this action results in death. Implementation of decisions to withhold or withdraw life-sustaining treatments must follow the guidelines set out in VHA Handbook 1004.02 and VHA Handbook 1004.3 and current STVHCS Informed Consent policy.

R.3.14 Forced Administration of Psychotropic Medication. Federal and state law dictate process regarding the forced administration of psychotropic medications in the context of involuntary commitments. The patient (or surrogate) must be allowed to consult with independent specialists, legal counsel, or other interested parties of their choice concerning treatment with psychotropic medication.Any recommendation to administer or continue psychotropic medication against the patient's wishes (or surrogate's wishes), must be reviewed by a multi-disciplinary committee appointed by the Facility Director for this purpose. The patient, surrogate, or a representative on the patient's behalf may appeal the psychotropic medication treatment decision to a court of appropriate jurisdiction. The patient and surrogate, if applicable, must be informed of the right to appeal the decision.

R.3.15 Organ Donation (See current version of Policy Memorandum 11-2009-01 for further instruction): STVHCS shall participate in area organ and tissue donation programs to identify potential organ donors and to inform families of patients about the patient's decision to donate or the family's option to donate or decline donation of organs, tissues, and/or eyes.

SECTION R.4 CONDUCT OF CARE

R.4.1 The same quality of patient care will be provided by all individuals with delineated clinical privileges or scope of practice, within and across services and between all Medical Staff Members.

R.4.2 There will be a comparable quality of surgical and anesthesia care throughout this Medical Center.

R.4.3 Electroconvulsive therapy is not performed on children or adolescents in this facility.

R.4.4 Behavior modification procedures that use aversive conditioning are not done in this facility.

R.4.5 Care treatment and services will be coordinated among the practitioners involved in a patient's care, treatment and services, and with other hospital personnel as relevant.

R.4.6 Dedicated Acute-assessment Rapid Response Team (DARRT). (See Policy Memorandum 11-2009-73 or current version for further instruction.) Provides early and aggressive intervention and management of patients with early signs of clinical deterioration and to provide stabilization and/or transfer to a higher level of care for patients with acutely de-compensating conditions. The DARRT is a team of clinicians who bring critical care expertise to the patient bedside. The DARRT is not expected to perform the responsibilities of the primary team to which the patient has been admitted. Thus, it is expected that the primary team will assist the rapid response team responders in caring for a patient for whom the DARRT has been activated to evaluate. If a higher level of care is required, the primary team is responsible to write the transfer order.

R.4.7 Orders for Do Not Resuscitate; Withholding and Withdrawal of Life-Sustaining Treatment (See R.8 Patient Orders).

R.4.8 Hospital Utilization of Seclusion and Restraint. (See Policy Memorandum 11-2009-29 or current version for further instruction.)

R.4.8.1 Restraint may be medically necessary to ensure delivery of treatments outlined in the patient's medical or surgical plan of care. Restraint is limited to emergencies in which there is an imminent risk of a patient physically harming him or herself, staff, or others, and nonphysical interventions would not be effective and may only be considered after completion of an assessment aimed at identifying the etiology (ies) of the specific behavior(s) for which restraint/seclusion is considered.

R.4.8.2 Restraint requires an order by a licensed independent practitioner for non-behavioral health purposes. The licensed independent practitioner may delegate authority to resident physicians to write orders for non-behavioral health purposes. If a licensed independent practitioner /designee are not available to order the use of restraint for non-behavioral health purposes, a RN can initiate use based on an assessment of the patient.

R.4.8.3 If a Registered Nurse initiates use of restraint for non behavioral health purposes, a licensed independent practitioner/ designee is notified immediately. The LIP must provide a verbal or written order within 12 hours of initiation and must examine the patient within 24 hours of initiation of restraint used for non-behavioral health purposes and enter a written order into the patient's medical chart.

R.4.8.4 If restraint for non-behavioral health purposes is continued beyond 24 hours, its use is ordered once each calendar day by a licensed independent practitioner/designee, based on his or her examination of the patient.

R.4.8.5 For behavioral health purposes, the licensed independent practitioner who is primarily responsible for the patient's ongoing care orders the use of restraint or seclusion for behavioral health purposes. In the absence of the primary licensed independent practitioner (LIP), his or her designee or other LIP may write orders for restraint or seclusion. This order must be behavior-specific, time-limited and be accompanied by written clinical justification and specification of the conditions under which restraints/seclusion may be discontinued. Restraint or seclusion orders may never be written on a standing or on an as needed (PRN) basis.

R.4.8.6 Restraint must be applied in accordance with safe and appropriate techniques and in a manner that does not cause harm or undue physical discomfort to the patient. Leather restraints are not permitted in the STVHCS.

SECTION R.5 SUPERVISION OF RESIDENTS (See Policy Memorandum 11-10-30 or current version for further instructions.)

R.5.1 Supervising practitioner refers to licensed, independent physicians, dentists, podiatrists, and optometrists, regardless of the type of appointment, who have been credentialed and privileged at STVHCS in accordance with applicable requirements. A supervising practitioner must be approved by the sponsoring entity (affiliate) in order to supervise residents. Other health care professionals with documented qualifications and appropriate academic appointments (i.e., psychologists, audiologists), may function as supervising practitioners for selected training experiences. Supervising practitioners can provide care and supervision only for those clinical activities for which they have clinical privileges. **NOTE:** The term "supervising practitioner" is synonymous with the term "attending" or "faculty".

R.5.2 Within the scope of the training program, all residents must function under the supervision of supervising practitioners. Services that provide 24-hour, 7-day a week (24/7) services and resident coverage must provide call schedules to the medical center administration. Call schedules are to delineate both resident and attending coverage.

R.5.3 In the ambulatory setting, it is expected that an appropriately-privileged supervising practitioner is available for supervision during clinic hours. Patients followed in more than one clinic must have an identifiable supervising practitioner for each clinic. Supervising practitioners are responsible for ensuring the coordination of care that is provided to patients. The supervising practitioner must be physically present in the clinic area during clinic hours.

R.5.4 Delegation or substitution of supervising practitioner: Other supervising practitioners may at times be delegated responsibility for the care of the patient and the supervision of the residents involved in the care of the patient.. It is the responsibility of the supervising practitioner to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access a supervising practitioner at all times.

R.5.5 The supervising practitioner is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident is involved in the care of the patient, the responsible supervising practitioner must continue to maintain a personal involvement in the care of the patient. Each patient must have a supervising practitioner whose name is identifiable in the patient record. The supervising practitioner directs the care of the patient and provides the appropriate type of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. All services must be rendered under the supervision of the responsible practitioner or must be personally furnished by the supervising practitioner.

R.5.6 Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected within the resident progress note or other appropriate entries in the medical record (e.g., procedure reports, consultations, discharge summaries). Pathology and radiology reports must be verified by a supervising practitioner. Types of allowable documentation are: (See Policy 11-10-30 for setting specific requirements and limitations on documentation types.)

(a) Progress note or other entry into the medical record by the supervising practitioner.
(b) Addendum to the resident progress note by the supervising practitioner.
(c) Co-signature of the progress note or other medical record entry by the supervising practitioner. **NOTE:** Supervising practitioner's co-signature signifies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of "additional signer" or "identified signer" options in CPRS is not an acceptable form of documenting resident supervision.
(d) Resident progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner's oversight responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment.

R.5.7 All notes and orders in the medical record made by medical students must be reviewed and countersigned by the responsible resident or attending physician.

R.5.8 Residency Program Directors will define the level of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. These responsibilities will be reviewed and approved by the Executive Committee of the Medical Staff.

SECTION R.6 ASSOCIATE MEDICAL STAFF OVERSIGHT

R.6.1 Physician Assistant (PA): One supervising physician must be designated the primary supervisor for each PA and shall sign the PA's scope of practice. Supervising physicians may only supervise the activities for which they are privileged. The Scope of Practice is specific to the routine, non-routine duties,

responsibilities and prescriptive authority of the PA, who is the supervising physician's agent in the provision of patient care. The Scope of Practice will be reviewed every six months as part of the ongoing periodic performance evaluation.

R.6.2 Advance Practice Nurse (APN) (Clinical Nurse Specialists and Nurse Practitioners): One supervising physician must be designated the collaborating physician for each APN and shall sign the APN's scope of practice. Collaborating physicians may only supervise the activities for which they are privileged. The Scope of Practice is specific to the routine, non-routine duties, responsibilities and prescriptive authority of the APN who functions independently or in collaboration with the health care team in the observation, assessment, diagnosis, intervention, care, counseling, and health teachings of clients in the promotion and maintenance of health and prevention or management of illness. The Scope of Practice will be reviewed by the collaborating physician every six months as part of the ongoing periodic performance evaluation.

R.6.3 Rules Specific to Physician Assistant and Advance Practice Nurse

R.6.3.1 Duties of the supervising physician include periodic assessment of patient care as evidenced by any of the following: direct observation of the APN/PA's care; discussion of the care with the APN/PA; or review of the medical records. The supervising physician need not be physically present when care is being provided, but must be available for consultation by telephone or other electronic means. Non-routine duties can be performed by the Nurse Practitioner after consultation with the physician supervisor, or alternate. During the performance of these duties, a physician must be immediately available for consultation by telephone and, if summoned, must be physically present at the site of the procedure within 15 minutes. The APN/PA will document consultation advice through a progress note in the electronic medical record.

R.6.3.2 When the supervising physician is unavailable for his/her supervisory duties, another qualified physician must be designated as supervising physician.

R.6.3.3 APN/PA's are authorized to write medical orders on inpatients and outpatients. Every order or prescription written by the APN/PA will be within the parameters of their state licensure and scope of practice. All orders, discharge summaries, progress notes, consultation requests, and history and physical examinations which are written by the APN/PA will clearly be identified as such in the written or electronic medical record.

R.6.3.4 Each inpatient's initial history and physical examination, and discharge summary must be co-signed by the supervising physician. Rejection of care requires a physician co-signature. The supervising physician must document findings and recommendations regarding the inpatient H&P and treatment plan in the form of an independent progress note or an addendum to the APN/PA note which must be entered by the end of the calendar day following admission.

R.6.3.5 For quality assurance purposes, at least two patient care records will be reviewed by the supervising physician on a monthly basis. The record of this review is to be kept in the service and used toward ongoing periodic performance evaluation.

R.6.3.6 The prescribing practices of the APN/PA will be periodically reviewed by the supervising physician to assure that the APN/PA is prescribing within the APN/PA's identified scope of practice. These practices may include chart reviews and periodic reviews of VISTA printouts of prescriptions (provided by pharmacy) and orders by the provider at a minimum every six months with the ongoing periodic performance evaluation.

R.6.4 Chiropractor

R.6.4.1 Doctors of Chiropractic are independent health care providers who function under a scope of practice to provide examination, diagnosis, treatment, and management of neuromuscular and musculoskeletal conditions using non-pharmacologic and non-operative methods. Chiropractors utilize standard medical evaluation procedures, along with biomechanical assessments, to establish a diagnosis and formulate a management plan. They consult with other health care providers and refer patients in accordance with accepted medical indications. Chiropractic treatment includes a number of options such as patient education, therapeutic exercise, lifestyle recommendations, and other interventions such as joint manipulation and mobilization, soft tissue therapies, and physical modalities.

R.6.4.2 The chiropractor functions under the indirect medical supervision of the Chief of Physical Medicine and Rehabilitation (physician). When the Chief of Physical Medicine and Rehabilitation is unavailable, another qualified physician must be designated.

R.6.4.3 Every order written by the chiropractor will be within the parameters of his/her state licensure and scope of practice. All orders, progress notes, consultation requests, and history and chiropractic physical examination which are written by the chiropractor will clearly be identified as such in the written or electronic medical record.

R.6.4.4 For quality assurance purposes, at least two patient care records will be reviewed by the Chief of Physical Medicine and Rehabilitation or physician designee on a monthly basis. The record of this review is to be kept in the service and used toward ongoing periodic performance evaluation. The Scope of Practice will be reviewed by the supervising physician every six months as part of the ongoing periodic performance evaluation.

R.6.5 Clinical Pharmacy Specialist (CPS)

R.6.5.1 One supervising physician must be designated the primary supervisor for each CPS and shall sign the CPS scope of practice. Supervising physicians may only supervise the activities for which they are privileged. The Scope of Practice is specific to the routine, non-routine duties, responsibilities and prescriptive authority of the CPS, who is the supervising physician's agent in the provision of patient care. The Scope of Practice will be reviewed every six months as part of the ongoing periodic performance evaluation.

R.6.5.2 When the supervising physician is unavailable for his/her supervisory duties, another qualified physician must be designated as supervising physician.

R.6.5.3 Duties of the supervising physician include periodic assessment of patient care as evidenced by any of the following: direct observation of the CPS's care; discussion of the care with the CPS; or review of the medical records. The supervising physician need not be physically present when care is being provided, but must be available for consultation by telephone or other electronic means.

R.6.5.4 Activities performed by the CPS shall include those Routine and Non-Routine Duties as assigned by the Supervising Physician. All activities performed by the CPS will be documented in a progress note in the patient's electronic record.

R.6.5.5 The CPS is authorized to prescribe medications within the VA formulary as authorized in the scope of practice. Initiation of controlled substance therapy is NOT authorized. The CPS may continue controlled substance therapy as authorized in the scope of practice that has been prescribed by a physician.

R.6.5.6 For quality assurance purposes, at least two patient care records will be reviewed by the supervising physician on a monthly basis to include elements of routine and non-routine duties authorized within this scope of practice. A record of this review will be forwarded to the appropriate Service Chief for review and inclusion in the ongoing professional practice evaluation process.

R.6.5.7 The prescribing practices of the CPS will be periodically reviewed by the supervising physician to assure that the CPS is prescribing within the CPS's identified scope of practice. These practices may include chart reviews and periodic reviews of VISTA printouts of prescriptions and orders by the provider at a minimum every six months with the ongoing periodic performance evaluation.

SECTION R.7 ADMISSIONS, TRANSFERS, AND DISCHARGES

R.7.1 ADMISSIONS (See Policy Memorandums 11C-07-05 Admissions, 11-06-44 Telemetry, 11-2009-06 Special Care Units, 11-2009-43 Geriatric and Extended Care Referral**,** or 11-08-18 Bartter Research Unit, or current version(s) for further instruction.)

R.7.1.1 STVHCS can accept only those patients for care and treatment who are medically and legally eligible as defined by current law and by policies of the VHA and this VAMC. 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 that he/she can be either transferred to another health care facility or other appropriate disposition within the community.

R.7.1.2 Provisions for services not rendered: Applicants who are found to have emergent problems that require services not rendered at STVHCS such as major trauma or emergent obstetrical admissions will be stabilized as possible and then transferred to the closest hospital providing the appropriate level of care.

R.7.1.3 Only members of the Medical Staff with admitting clinical privileges will be permitted to admit patients. House-staff admit patients under supervision of Medical Staff with admitting clinical privileges. The admitting staff with privileges for admission is responsible for seeing that each applicant who presents and applies for care is examined to determine the applicant's need for medical treatment and ongoing treatment until admission.

R.7.1.4 The Emergency Department (ED) staff physicians have authority for admitting to all services and subspecialties except to Psychiatry.

R.7.1.5 Psychiatry Service physicians with admitting privileges will assess psychiatry patient(s) and evaluate the need for admission or other disposition.

R.7.1.6 All other admitting staff physicians within the STVHCS have admission privileges to their respective bed sections such as acute care, spinal cord injury, or long term care. Admitting staff with patients needing admission outside of their respective services should consult the appropriate service. The consulted service may choose to admit directly; to evaluate the patient in their clinic; or to evaluate the patient in the ED if their clinic is closed. All consultants will evaluate patients in a timely fashion and will make a legible note in the patient's medical record. When there is a disagreement about the need for consultation and/or admission, the attending staff of the respective services should consult with each other. If a satisfactory solution cannot be reached, the Chief of Staff will make final disposition.

R.7.1.7 Physician Directors or attendings with admitting privileges within the Cardiac Care Unit (CCU), Medical Intensive Care Unit (MICU), and Surgical Intensive Care Unit (SICU) are responsible for making admission decisions in consultation with the physician responsible for the patient. The anesthesiology and surgical specialty team are responsible for the care of patients in the SICU. Unstable or post code patients on acute medicine or surgery units will be transferred immediately to the Intensive Care Unit of the primary service managing the case (i.e. medical services to MICU or CCU and surgical services to SICU). Outpatients undergoing treatment and/or procedures who become unstable will also be admitted to the ICU of the primary service managing the case (i.e. vascular surgery to SICU or renal to MICU or CCU).

R. 7.1.8 Telemetry (See Policy Memorandum 11-06-44 or current version): The admitting physician is responsible to order continuous electrocardiogram monitoring (telemetry) and to ensure the patient is admitted to a unit with telemetry for patients who meet the telemetry criteria per clinical guidelines.

R. 7.1.9. Long-term care services includes all institutional, home- and community based services that the VA provides, coordinates, or purchases. The Geriatrics Extended Care (GEC) Referral is required before acceptance to any of the following programs: STVHCS Community Living Care Units, Contract Nursing Homes, Community Residential Care Homes, Home-Based Primary Care, Adult Day Health Care, Skilled Home Care, Homemaker/Home Health Aide, in- and outpatient hospice services, and in- or outpatient respite services. The GEC Physician/LIP Section of the GEC Referral will be completed by a physician or licensed independent practitioner. In general, the physician or LIP will initiate the GEC referral form by: completing the GEC Care Recommendation Section; placing a consult to Geriatrics and Extended Care, and completing a quick order set that notifies nursing staff that a GEC referral form has been initiated. These three tasks are linked together in CPRS so that one follows the completion of the other automatically.

R.7.1.10 Admission to the Bartter Research Unit: The Chief of Medicine (or delegated alternate physician) is responsible for clinical oversight of this unit, including admitting privileges, quality of care, direction and strategic planning. The Institutional Review Board (IRB) of The University of Texas Health Science Center at San Antonio (UTHSCSA), the Department of Veterans Affairs (VA) Research and Development (R&D) Committee must approve all studies carried out on the BRU. The principal investigator or co-investigator, licensed physicians with clinical care privileges at ALMD, are responsible for managing all aspects of patient care for the research volunteers related to study protocols, including all required medical record documentation of an inpatient unit.

R.7.1.11 The admission and subsequent care of a dental or podiatric patient shall be a dual responsibility of the dentist or podiatrist and a physician member of the Medical Staff. The physician shall be responsible for the care and/or supervision of the care provided by house-staff of any medical problem present on admission or that may arise during the rest of the patient's hospitalization. A podiatrist with clinical privileges may, with the concurrence of an appropriate member of the Medical Staff, initiate the procedure for admitting a patient. A Medical Staff member shall assume responsibility for the overall aspects of the patient care throughout the stay. Patients admitted to the Medical Center for podiatric care must be given the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff must be responsible for the care of any medical problem that may be present or may arise during the hospitalization of a podiatric patient. Dentists and podiatrists who admit patients for care are responsible for documenting the part of the patient's history and physical examination that is related to their discipline within 24 hours of the patient's admission to the medical center.

R.7.2 TRANSFER OF PATIENTS

R.7.2.1 Patients shall not be transferred from one Bed Service to another or out of an ICU or Recovery Room without a written order in the chart by the Medical Staff or house-staff responsible for the patient's care and the completion of the appropriate transfer documentation.

R.7.2.2 Transfers from one Bed Service to another will be accomplished only by mutual agreement of the Bed Services involved.

R.7.2.3 There shall be an off service transfer note written on the progress notes by the transferring service. It shall be a concise recapitulation of the hospital course to date and developed to assist the receiving physician or dentist to ensure continuity of care. Inter-ward transfers between Divisions require a completed interim summary.

R.7.2.4 There shall be an transfer accept note written on the progress notes by the accepting service that includes a medicine reconciliation for transfer

R.7.2.5 There will be an attending note written on the progress notes by the accepting service attending by the following day.

R.7.2.6 Orders will automatically be canceled on moving from one service to another.

R.7.2.7 A Health Unit Coordinator or a Nurse will be responsible for promptly notifying the receiving staff professional as soon as a new patient has arrived on the ward.

R.7.2.8 Although the day-to-day treatment of the patient, such as writing patient care orders, may be delegated to the house-staff, the responsibility for the patient's care rests with the Medical Staff member. The Medical Staff member shall be responsible for all medical care and treatment, and for the prompt completion and accuracy of the medical record. Whenever these responsibilities are transferred to another staff member or service, or to another health care facility, an entry by the transferring physician covering the transfer shall be entered in the medical record. In addition, accurate, clear, and complete information, using interactive communication about the patient's (1) care, treatment, and services. (2) current condition, (3) any recent or anticipated changes, and (4) an updated medication list must be completed prior to the transfer.

R.7.3 DISCHARGE OF PATIENTS (See Policy Memorandum 11-2009-08 Discharge from Inpatient Care or 136-08-30 Completion of Medical Records or current version for further instruction).

R.7.3.1 A patient will be discharged from inpatient care when the patient's attending physician determines that the patient no longer requires continued inpatient services, a suitable discharge location has been arranged and all indicated post-discharge medical needs are arranged within the scope of care and the authority of the STVHCS.

R.7.3.2 The health care team will develop a discharge plan through regularly scheduled interdisciplinary conferences and/or rounding to assist the patient in the transition between inpatient care, community agencies and/or home. Discharge planning activities, including patient education, will be documented in the clinical record by the discipline engaged in the activity or a team note.

R.7.3.3 A team practitioner will communicate the patient's estimated length of stay to the Social Worker as soon as possible after admission. The team practitioner will also participate in the discharge planning meetings, communicating the patient's medical status, anticipated care and date of discharge.

R.7.3.4 Whenever possible, the practitioner will complete the anticipated discharge order in the electronic medical Record. Orders will include the date of discharge, follow-up care appointments, equipment, travel needs (including completion of the travel certificate), medication reconciliation list and fill hold for all discharge medications and prescriptions by 1:00 p.m. the day prior to discharge or by 1:00 p.m. on Friday for all weekend discharges.

R.7.3.5 The practitioner is encouraged to type or dictate the discharge at or before discharge. A discharge handoff document (discharge handoff note or discharge summary) must be visible in the record at or before discharge. The discharge summary should be completed within 24 hours of hospital (acute care) discharge, including situations of irregular discharge or death.

R.7.3.6 The discharge handoff note and/or summary will include: (1) Concise summarization including the reason for hospitalization and the care, treatment, and services provided; (2) The procedures/operations performed; (3) Items for immediate follow-up (labs, pending reads, etc.); (4) The

patient's condition on discharge; (5) Information provided to the patient and family; (6) Provisions for follow-up care.

R.7.3.7 A medical record, which remains incomplete more than 30 calendar days following discharge of the patient, will be considered a delinquent record.

R. 7.3.8 Against Medical Advice (AMA). The physician is responsible for providing the patient with information regarding the potential risk(s) associated with a premature discharge and the benefits of a continued/completed hospitalization to allow the patient options in making an informed decision. The physician will instruct the patient (who has decision-making capacity and is not a danger to self or others) to sign the AMA Personal Release Form. The physician will order all necessary medications and place orders for any necessary supplies. A medication reconciliation note should be completed and offered to the patient if the situation allows.

SECTION R.8 HISTORY AND PHYSICAL EXAM (See current version of Policy Memorandum 11-08-24, Assessment of Patients, or 136-08-30, Completion of Medical Records, for further guidance.)

R.8.1 History and Physical Exam (Inpatient, Outpatient, and Community Living Center): The minimal content of the history and physical exam will include sufficient information to identify the patient, to support the diagnosis, to justify the treatment and to document the results accurately, as follows:

R.8.2 The basic medical appraisal required elements will include:
(a) Chief complaint (CC);
(b) Appropriate new patient history or interim history of present illness (HPI);
(c) Complete or targeted physical examination appropriate for the CC and HPI;
(d) Assessment based on documented objective or subjective data including a provisional diagnosis and/or appropriate differential diagnosis where indicated;
(e) Clinical observations documented if applicable (e.g., results of therapy and medication);
(f) Plan of care to include requests for follow-up appointments as appropriate.

R.8.3 Additional elements as appropriate:
(a) Documentation of required reporting if applicable (e.g. adverse drug reactions, suspected abuse, reportable infectious disease, homeless).
(b) Documentation of informed consent.
(c) Outpatient medication reconciliation note.
(d) Problem list updated to include all active medical problems.

R.8.4 Inpatient Admission: A medical history and physical examination (H&P) are completed (written and signed) no more than 30 days prior to or within 24 hours after inpatient admission. If an H&P has been performed within 30 days prior to admission and recorded in the electronic medical record, an update progress note must be completed which includes a reference to the H&P by specific date in addition to updates to the patient's medical condition. This progress note must be completed within 24 hours of admission or prior to the surgery or a procedure requiring anesthesia services, whichever comes sooner. The H&P and required updates are the responsibility of the admitting physician or oral surgeon Medical Staff Member with approved privileges.

R.8.5 House Staff (physicians and oral surgery residents) may complete and sign the H&P to meet the standard of 24 hours after admission.

R.8.6 A Medical Staff Member supervising physician (doctor of medicine or osteopathy) may delegate all or part of the medical history and physical examination to a Physician Assistant or Advanced

Practice Nurse who has those duties approved on a current scope of practice. The physician who delegated the H&P must meet all required H&P elements.

R.8.7 The supervising physician must physically meet, examine, and evaluate the patient within 24 hours of admission including weekends and holidays. Documentation of the supervising physician's findings and recommendations regarding the H&P and treatment plan must be in the form of an independent progress note or an addendum to the House Staff, Physician Assistant or Advanced Practice Nurse note and must be entered by the end of the calendar day following admission. Note: The time requirement for seeing and evaluating the patient (within 24 hours) is different from that of documentation in the medical record by the supervising practitioner (by the end of the calendar day following admission).

R.8.8 Dentists and podiatrists who admit patients for care are responsible for documenting the part of the patient's history and physical examination that is related to their discipline within 24 hours of the patient's admission to the medical center. The physician attending of the medical team admitting the patient will retain primary responsibility for the overall medical care of the patient, including the complete history and physical exam.

R.8.9 The history and physical examination and the results of indicated diagnostic tests are recorded before the operative or other high-risk procedure, except in emergencies. If they are not, the surgery shall be canceled unless the surgeon states in writing in the medical record that such delay would constitute a hazard to the patient.

R.8.10 Community Living Center and Hospice: A medical history and physical exam shall be written and signed within 72 hours of admission.

R.8.11 Moderate Sedation: The physician or dentist with moderate sedation privileges is responsible for performing a Pre-Sedation Analgesia assessment (which serves as the H&P) and for developing a sedation/analgesia plan that includes the appropriate level of post-procedure care. The Pre-Sedation Analgesia Assessment or H&P includes the following required elements:

(a) Medical history and physical status assessment: age, review of systems, level of consciousness, vital signs, oxygen saturation, airway assessment, cardiopulmonary reserve, pregnancy status, pre-procedure pain;
(b) Physical condition that might affect decisions regarding pre, intra and post procedure management and potential risks;
(c) Diagnostic tests;
(d) Past and present drug history;
(e) Any known allergies;
(f) History of tobacco, alcohol and substance use/abuse;
(g) Anesthesia history including previous adverse experiences with sedation and analgesia as well as with regional and general anesthesia;
(h) ASA classification;
(i) Patient NPO status pre-sedation;
(j) Transportation arrangements;
(k) Plan and choice of sedation.

R.8.12 Monitoring: The Organized Medical Staff monitors the quality of medical histories and physical examinations through service specific clinical pertinence peer review, through appropriate supervision of residents and associate medical staff who initiate history and physical examination, and through participation in the organizational peer review program.

SECTION R.9 PATIENT ORDERS

R.9.1 Orders are entered into the electronic medical record (EMR).

R.9.2 The following providers are authorized to write orders in the medical record: 1) licensed independent providers who hold clinical privileges; 2) providers who are authorized to write orders through a scope of practice i.e. Physician assistants, advance practice nurses (nurse practitioners and clinical nurse specialists), certified registered nurse anesthetists, clinical pharmacists, and chiropractors; and 3) authorized house staff who are graduates of medical, osteopathic, dental, podiatry, or optometry schools.

R.9.3 If an order is felt to be unsafe for the patient, the registered nurse or registered pharmacist will resolve this with the prescribing practitioner if possible. If not resolved, the staff physician on-call for the service will be consulted.

R.9.4 Standardized Order Sets (protocols): Standardized order sets are reviewed periodically by Section or Service Chief and modified as needed. All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by medical staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief.

R.9.5 Do Not Resuscitate (DNR); Withholding and Withdrawal of Life-Sustaining Treatment (See Policy Memorandum 11-07-17 or current version for further instruction).

R.9.5.1 DNR: The attending physician, not a resident, will have the specific responsibility for determining DNR and/or withholding/withdrawing life-sustaining treatment and for the appropriate documentation in the electronic medical record.

R.9.5.2 HOUSESTAFF ORDERS: Before writing the DNR order, the resident must obtain consent from the patient or their authorized surrogate, discuss the order with the attending physician responsible for the patient's care, obtain the attending's concurrence, and document the conversation with the attending in the patient's medical record. The resident will write the DNR order only after verbal or telephone confirmation from the attending physician who is satisfied that all requirements for a DNR order have been met. A "DNR Status/Physician Progress Note" template will be entered in the computerized patient record system (CPRS). The attending must countersign the progress note documenting the conversation and rewrite the DNR order within 24 hours.

R.9.5.3 DNR Orders in the Operating Room: DNR orders carry no necessary implication about a patient's candidacy for surgery, intensive care or any other treatment measures except cardiopulmonary resuscitation. DNR orders are not automatically suspended during surgery. The attending physician, surgeon and/or anesthesiologist discuss with the patient or surrogate decision maker any proposed suspension of the DNR order or advance directive during the operative and peri-operative period. Anesthesia and its risks are explained to the patient or surrogate decision maker during the pre-anesthetic workup. Alternative treatment options other than surgery are reviewed with the patient and/or surrogate decision maker. The attending physician documents the discussion and the resultant decision either to continue or rescind the DNR order or advance directive.

SECTION R.10 VERBAL/TELEPHONE ORDERS

R.10.1 Verbal Orders: Verbal practitioner orders (when the practitioner is present or available in the facility) will be accepted only in life threatening circumstances. Orders will be recorded and signed by the practitioner upon resolution of the emergency. Registered nurses and physician assistants may accept verbal orders within their areas of expertise. The authorized person receiving the verbal order will first write down the order and then read back the order to the practitioner to ensure correctness. These orders will include the name of the practitioner who issued them and be signed, timed and dated by the person who received them.

R.10.2 Telephone Orders: Telephone orders (verbal orders given via telephone) will be accepted and followed when the practitioner is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS and when it clearly is in the best interest of patient care. Registered nurses and registered dietitians are authorized to accept telephone orders. The registered nurse receiving the telephone order will first write down the order and then read back the order to the practitioner to ensure correctness. Telephone orders will be documented in the medical record, signed, timed and dated by the registered nurse who received them with the notation of the practitioner who dictated the order. The order must be signed electronically by the ordering practitioner within 24-hours or the next working day whichever is earlier.

R.10.3 Pharmacists will take verbal and telephone orders to clarify and subsequently to make changes to inpatient medication orders and outpatient pharmacy prescriptions.

SECTION R.11 ORDERS AND MEDICATIONS (See Policy Memorandum 119-2009-13 Controlled substances; 119-07-09 Non-Formulary Medications; 119-08-05 Investigational Drugs; 11-2009-42 Medication Use Management; 119-2009-27 Self- Administration or current version(s) for further instruction.)

R.11.1 All drugs used in the Facility will be stored and dispensed by the Pharmacy. All drugs used in STVHCS must be on the National Formulary or as additions approved by the VISN 17 Pharmacy and Therapeutics (P&T) Committee or be Investigational Drugs that have been approved by the Research and Development Committee and the Facility Pharmacy and Therapeutics Committee. Nonformulary medication usage will be appropriate only under the circumstances listed in current policy and only after a Nonformulary Electronic Consult Request has been completed, submitted for consideration, and approved. Authorized prescribers for investigational drugs must be listed on form 10-9012 as approved through the research protocol.

R.11.2 Outpatient Controlled Substance Prescriptions:

R.11.2.1 Schedule II Controlled Substances: Prescriptions must be written on VA Form 10-2577F or other approved form. The prescriptions must be dated as of, and signed on, the date issued. No refills will be allowed. Quantities will be limited to a seven (7) day supply unless indicated for chronic pain management or oncology patients. Prescriptions may not be filled if they are more than 30 days old when presented.

R.11.2.2 Schedule III-V Controlled Substances: Prescriptions may be electronically ordered in the electronic medical record for a quantity not to exceed a 30-day supply. Refills for controlled substance prescriptions will have the following restrictions: a. No more than five (5) refills will be authorized. b. No prescriptions over six (6) months old will be refilled regardless of the number of refills authorized or remaining unused.

R.11.3 Ordering Medications:

R.11.3.1 The organization maintains a complete and readily available formulary (including strength and dosage) for ordering. Medication substitution protocols are developed and approved per recommendations provided by the VHA Pharmacy Benefits Management Group and Medical Advisory Panel, VISN 17 and STVHCS Pharmacy and Therapeutics Committee to address drug shortages and outages.

R.11.3.2 All medications and treatments are administered only on the order of an individual who has been specifically granted clinical privileges to write such orders.

R.11.3.3 All medication orders will include date and time written, drug name (generic or brand name), the dosage strength, the frequency and route of administration, and directions for use. Orders not completely written will not be processed for dispensing.

R.11.3.4 Indication for use: A documented diagnosis, condition, or indication for use exists for each medication ordered. Medications orders do not require a listing of medical indication for the drug in the order entry itself. The pharmacist will use professional judgment to evaluate all information available (CPRS, problem list, therapy indications) to determine the appropriateness of the drug orders.

R.11.3.5 Medication related devices such as nebulizers and aero chambers are ordered for inpatients utilizing "text order" function in CPRS.

R.11.3.6 Medication orders must be written when patients are admitted to an observation or inpatient bed, and rewritten when patients are transferred to another service or STVHCS facility, and/or transferred to or from intensive care units or the operating room.

R.11.3.7 Prescriber changes in medication with respect to dosage, route, or frequency constitute a new order and automatically cancel any previous order.

R.11.3.8 Range orders constitute a spread or measure of difference between small and large representation of possible doses. Providers must include specific criteria for dosing medications in range orders. Range orders that lack specific criteria for dosing will be automatically changed by Pharmacy Service to the lower dose of medication and/or the longer dosing frequency.

R.11.3.9 Outpatient "PRN" medication orders must clearly state the condition(s) under which these medications are to be administered. An outpatient "PRN" order without a written reason or condition for administration is unacceptable and the prescriber will be contacted for clarification.

R.11.3.10 Hold Orders. Inpatient "Hold" Medication Orders will automatically result in the medication being discontinued. Prescribers must enter a new order to reinstate the medication order. Outpatient "Hold" Medication Orders will be held until the prescriber reinstates the order. A written order stating, "resume previous medication orders" is unacceptable.

R.11.3.11 Standing orders are a group of orders that commonly apply to all or almost all patients in a like category. They are a starting point in writing orders and must be individualized for each patient. Orders for medications in a group of standing orders must contain all elements of a complete medication order.

R.11.3.12 Automatic stop orders will be adhered to in accordance with current VHA and Federal/State regulatory policies. An automatic stop order does not apply when the number of doses or an exact period of time is specified. All automatic stop orders expire at 2400 hours on the day noted below unless otherwise specified:

(a) For all acute inpatient bed services all medication orders will automatically expire at the end of 28 days with the following exceptions:

1. Controlled drugs (Schedule II through IV) expire at 2400 hours of the third day, except for Lorazepam and Triazolam which expire in 14 days
2. Parenteral antibiotic orders expire at 2400 hours of the fourth day. Other antibiotics, antifungals, and topicals other than antifungals should be ordered for a specified therapeutic time
period.
3. IV fluids expire at 2400 hours on the 28th day from the time of original order unless the order specifies a number of days or the total number of bags of solution.
4. Clozapine orders expire in 28 days

(b) For long-term care inpatient bed services all medication orders, including controlled drug orders for management of documented chronic pain, automatically expire at the end of 28 days with

the following exceptions:

1. Controlled drug orders for acute pain, PRN medication orders without concurrent continuous medication orders, and cough syrup with codeine expire in seven (7) days
2. Hypnotics, benzodiazepines, and other psychotropic drugs expire in 14 days except when ordered for an established chronic disorder such as schizophrenia, seizures, chronic muscle spasticity,
or other documented neurological condition.
3. Antibiotics, antifungals, and topicals other than antifungals should be ordered for a specified therapeutic time period.
4. IV Fluid Orders will automatically expire at 2400 hours on the 28th day from time of original order unless the order specifies a number of days or the total number of bags of solution.
5. Clozapine orders expire in 28 days.

R.11.3.13 Hyperalimentation orders expire every 24 hours. Pharmacy Service must receive daily hyperalimentation orders by 1200 to begin a new order or to make changes effective the same day. The start time for all hyperalimentation solutions is 1800.

R.11.3.14 Medication orders prescribed as "STAT" will be available in 45 minutes or less after pharmacy notification. "NOW" medication orders will be available within 90 minutes from receipt of notification to pharmacy. Routine medication orders will be administered according to approved medication administration times.

R.11.3.15 Herbal remedy or medicinal are not available in the STVHCS Formulary.

R.11.3.16 Illegible, unclear, or incomplete medication orders will be clarified prior to dispensing and /or administration. If an order is felt to be unsafe for the patient, the pharmacist or registered nurse will resolve this with the prescriber, if possible. If unresolved, the next level supervisor will be consulted.

R.11.3.17 Discharge Medications: Outpatient Medications will remain active for the duration of the inpatient stay. At discharge, the patient's complete medication profile will be reviewed by the discharging physician and updated as warranted. This review must occur to avoid medication omissions and/or duplications. Discharge prescriptions will be for medications newly prescribed for the patient. These discharge medication orders should - be entered electronically in CPRS no later than 3 PM on the day prior to the planned release of the patient. It is required that any changes to the patient's inpatient medication orders be reflected in the Outpatient Medication Profile.

R.11.4 Self-Administration**:** Patients who are determined to be self-care may self-administer medications when properly ordered by a physician. Orders: (1) Shall not include controlled substances. Exception is made for controlled substances administered by way of Patient Controlled Analgesia (PCA) infusion pumps, which by design, ensure total drug accountability and prevent accidental over dosage. (2) Shall be limited to a 7-day supply.

R.11.5 Psychopharmacologic Agents (See Policy Memorandum 119-07-19 or current version for further instruction): Patient(s) maintained on atypical antipsychotics will have their BMI measured at baseline, weeks 4, 8, and 12 after initiation of therapy, and quarterly thereafter. Blood pressure will be monitored at baseline and quarterly thereafter. Fasting plasma glucose and fasting lipid panel will be obtained at baseline, week 12, and annually thereafter. Patients receiving antipsychotic medications will be screened for symptoms of Tardive Dyskinesia with the use of the Abnormal Involuntary Movement Scale per policy.

R.11.6 Tapering and Titrating: (See Policy Memorandum 119-07-24 or current version for further instruction): Taper orders must include the dose increment and time interval for the taper process. Titration

orders must include all three (3) elements listed below once a medication name and dose for admixture and solution name and volume to be infused have been selected. (1) Starting dose; (2) Maximum dose; (3) The desired outcome, the physiologic patient response/goal.

SECTION R.12 SURGICAL CARE (See current version of Policy Memorandum 11-08-24 Assessment of Patients or 11-10-36 Consent for further instruction)

R.12.1 Major surgical operations, other than emergency procedures, shall not be performed until adequate clinical data are recorded on the chart and blood count, urinalysis, and chest x-ray, if needed, are completed.

R.12.2 Pre-operative note: In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising or staff practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed. For admitted patients, if the attending admission note (or addendum) includes the specific requirements of the pre-operative note, it may also serve as the pre-operative note.

R.12.3 Pre-Anesthesia: The Anesthesiology Service member discusses the anesthesia plan with the patient or legal guardian, obtains the patient's previous anesthetic history, any history of unusual anesthetic problems in the patient's family, and informs the patient of the risks and benefits of the various anesthesia options for the surgical procedure. A pre-anesthetic note is made on the patient's chart to include a statement regarding discussion of the planned anesthesia management and the patient's apparent understanding and agreement. See Assessment of Patients Policy Memorandum for criteria for pre-anesthesia assessment. The staff nurse anesthetist who is so credentialed may perform evaluation of patients to include entering the pre-anesthesia note in the record.

R.12.4 Informed Consent (See R.3).

R.12.5 The signed informed consent(s) shall be in the medical record before the surgical procedure is begun.

R.12.6 Surgical Specimens (See Policy Memorandum 11-08-27 or current version for further guidance): All tissues and materials removed during surgery shall be sent to the STVHCS pathologist who shall make such examination or disposition as he/she may consider necessary to arrive at pathological diagnosis and to issue a signed report. The specimen shall be adequately labeled as to patient's name and tissue source and shall be accompanied by a tissue examination form with pertinent identification and clinical information.

R.12.7 In cases requiring an assistant, the assistant shall be a qualified physician, oral surgeon, or physician assistant. The assistant in a major operation must be another surgeon capable of continuing the operation if necessary. Medical students should act only in a second, third or fourth assistant capacity at major operative procedures in accordance with VHA regulations.

R.12.8 Medical students may be permitted to perform minor surgery such as closure of wounds and incisions, minor excision of cysts, etc., only when under the direct supervision of a qualified physician.

R.12.9 An immediate postoperative progress note or operative report must be entered in the medical record immediately following the surgery before the patient is transferred to the next level of care (usually 30 minutes after leaving the OR) and subsequently co-signed by the attending surgeon.. If the practitioner performing the operation (attending surgeon) or high-risk procedure accompanies the patient from the operating room to the next unit of care, the immediate postoperative progress note or operative report can be

written or dictated in the new unit or area of care. The immediate postoperative note must include the name(s) of primary surgeon and assistant(s), procedure(s) performed, description of each procedure finding, estimated blood loss, specimens removed, and post operative diagnosis. When an immediate postoperative note is completed a narrative operative report may be dictated in addition within 24 hours of surgery. The operative report must include all required elements indicated above in addition to the name of supervising practitioner (surgeon) and presence and/or involvement, and the names of the primary surgeon and assistants.

R.12.10 Post-Anesthesia: At the conclusion of anesthesia, the patient is evaluated for special postanesthetic management.

R.12.11 The physician responsible for anesthesia care or his/her designee makes decisions regarding the management of the patient and the evaluation of the patient's condition for discharge. Patients are released from the PACU by written order of the Anesthesia Service. A postanesthesia note is made in the Progress Notes describing the patient's physiologic condition upon anesthesia release from the PACU. Nurse anesthetists so credentialed, and acting for the Chief, Anesthesiology Service, may release patients from PACU using those criteria established and will enter a PACU release note in the patient's record.

R.12.12 A post-anesthesia follow-up note is recorded after the patient has been discharged from the PACU. This note describes the presence or absence of anesthesia related complications. (This pertains to patients remaining in the hospital 48 hours or more after anesthesia has been administered.)

R.12.13 A recorded post-anesthesia complication has follow-up notations describing the course of treatment and the results of treatment of the complication.

R.12.14 Dental surgical privileges (in the operating room) must be specifically defined in the same manner as all other surgical privileges and may be exercised only under the overall supervision of the Chief, Surgical Service.

SECTION R.13 CONSULTATIONS (See POLICY MEMORANDUM 11-2009-41 or current version for further instruction)

R.13.1 All internal consultations, inpatient and outpatient, shall be entered into the Electronic Consult Tracking (ECT) system. All consult actions will be designated electronically as defined in the VistA/CPRS Consult/Request Tracking User Manual.

R.13.2 All consult requests to a specialty clinic will be acted on within seven (7) business days of the request (this does not mean the appointment must be within 7 days, but that administrative action of scheduling or returning consult must be completed within 7 business days).

R.13.3 Consulting Provider is responsible to:
(a) Enter the electronic consult, with adequate clinical information, desired date and according to existing templates and service agreements.
(b) Contact the consultant provider by phone when request is urgent or consult is for an inpatient and response is needed as part of plan of care.
(c) Report findings of internal consultations to veteran patients and/or their family members.
(d) Take appropriate action based on the consult findings.
(e) Resubmit consult requests as needed.

R.13.4 Consultant Provider is responsible for either:
(a) "Completing" electronic consults, using the proper electronic note title after the consultation encounter, or if sending comments back to the consulting provider. When operative procedures are

involved, the results of the consultation, except in an emergency, shall be completed prior to the operation.

(b) OR "Canceling" the consult request, with electronic comment added to the consult explaining the cancellation.

R.13.5 Consultation is urged for the following situations:

(a) When the patient is not a good risk for an operative 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 his family and with concurrence by the attending physician.

(f) Psychiatric consultation shall be provided for all patients who have attempted suicide or who have had chemical overdoses.

R.13.6 Consultant - A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical Staff on the basis of the individual's training and experience and competency.

R.13.7 Residents or Fellows may act, as consultants when approved by the Clinical Service Chief, but all consultation notes should reveal the involvement of the supervising practitioner as follows: Inpatient/Outpatient Consultations--A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents.

R.13.8 Emergency Department Consultations. Residents from a consulting service are required to contact their supervising practitioners while the patient is still in the emergency department in order to discuss the case and to develop and recommend a plan of management. The emergency room practitioner is responsible for the disposition of the patient. The emergency room practitioner is not the supervisor of the consulting resident, but is the responsible practitioner for the patient.

R.13.9 Consultations are the formal means of professional communication about the patient. Consultations require professional conduct of the highest magnitude. The findings and opinions of the consultant should be made available only to the clinicians involved in the care of the patient. Patients or their families should not be apprised or advised by the consultant except with the consulting team's prior knowledge and consent.

R.13.10 If a nurse or any other professional has any reason to doubt or question the care provided to any patient and feels that appropriate consultation is needed and has not been obtained, he/she shall direct said question to the attending Medical Staff member. If after this, he/she still feels that the questions have not been resolved, it shall be called to the attention of his/her supervisor for resolution.

SECTION R.14 MEDICAL RECORDS

R.14.1 Entries in the electronic medical record (EMR) made by residents or Associate Medical Staff that require specific documentation by supervisory / attending medical staff members include:

(a) Medical history and physical examination (admission) (independent progress note or addendum)

(b) Consults (new and follow-up) (co-signature with addendum) (effective 10/1/10)

(c) Daily Progress Notes (co-signature with addendum) (effective 10/1/10)

(d) Discharge Summary (co-signature with addendum) (effective 10/1/10)

(e) Operative Reports (co-signature with addendum) (effective 10/1/10)
(f) Operative Pre-Procedure Note (independent note)
(g) Imaging Reports (verification)
(h) Certification of brain death (independent progress note)
(i) Orders for Research Protocols/Investigational Drug Usage (initiated by attending)
(j) Orders for DNR/Withdrawing or withholding life sustaining procedures (initiated by attending)

R.14.2 Medical Records will be created and maintained following the format approved by VHA or as modified and approved through the STVHCS Medical Records Committee.

R.14.3 A list of abbreviations not to use can be found in CPRS. Those abbreviations are not acceptable for use either handwritten or in the electronic medical record Final diagnoses, complications, and operation reports shall be recorded without the use of symbols or abbreviations.

R.14.4 Entries in the medical record (including transcription or dictation) are authenticated by the author within timeframes designated by policy. Authentication includes the time, date, signature (electronic) or initials and the professional designation. Completeness implies that all required data is present and authenticated. All providers with clinical privileges or scope of practice are expected to maintain active access to the electronic medical record (CPRS), and to enter all documentation into CPRS to meet policy requirements and timeframes. Failure to complete entries into the electronic medical record within designated timeframes may result in action against clinical privileges and/or disciplinary action.

R.14.5 Consultation (see R.13).

R.14.6 Progress notes should give a pertinent chronological report of the patient's course in the medical center and should reflect any change in condition that results in a change of treatment or diagnostic procedure plans. They should be authenticated and complete. They should be recorded at a frequency appropriate to the condition of the patient and shall serve as the evidence of reassessment by the provider. Each clinical event shall be fully documented in the EMR as soon as possible after its occurrence.

R.14.7 Acute Care and Intensive Care Unit Progress notes shall be entered at least daily by the attending service into the EMR (effective 10/1/10).

R.14.8 Community Living Center (Long Term Care) progress notes shall be entered into the EMR monthly either as independent note by the attending physician or co-signature by the supervising physician (attending) if entered by house staff, advance practice nurse or physician assistant.

R.14.9 The attending Medical Staff member or house staff shall enter a progress note into the medical record of each patient as soon after admission as possible to include:
The provisional diagnosis or recognized clinical problems; and the initial note stating the cause of hospitalization, the clinical findings, and the course of treatment contemplated.

R.14.10 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 Psychiatry Association shall be used to provide uniform disease and operation terminology.

R.14.11 In the event of death, 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.

R.14.12 Transfers (See R.7)

R.14.13 Discharge Summary (See R.7)

R.14.14 A physician member of the staff shall be responsible for the completed medical record for each patient. The medical record shall include: identifying data, medical history, chief complaints, history of present illness, an appropriate patient history, physical examination, provisional diagnosis, all diagnostic laboratory and radiological tests, medical treatments or procedures, surgical 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, follow-up and preliminary results of the autopsy when performed. No medical record shall be closed until it is complete except upon the recommendation of the Chief of Staff using established criteria.

R.14.15 The provider is responsible for the problem list. The primary care provider will initiate the problem list by at least the 3rd primary care visit. All other providers should appropriately update the problem list with active problems per specialty. Problem--A medical surgical, psychiatric, or social issue that is of sufficient concern that it warrants listing in the Problem List section of the medical record. Problems are named at their current stage of understanding, however, whenever a clear diagnosis is known, it is listed in preference to a symptom. Problems for listing require an ICD 9 diagnostic code. Problems may be acute or chronic, but their placement in the permanent record requires that they meet the following threshold: (1) The problem requires ongoing care; (2) The problem causes an ongoing symptom or disability; (3) The problem was acute and resolved, but it may affect ongoing care, as in the case of prior surgery.

R.14.16 Outpatient progress notes will be entered into the medical record and signed within 24 hours of the provider/patient encounter.

R.14.17 Laboratory Tests (see Policy Memorandum 113-10-08, Laboratory Test Results or current version for further instruction):

(a) All laboratory studies to be performed at STVHCS will be ordered electronically.

(b) Results of all laboratory studies performed at the STVHCS will be entered and verified in the Computerized Patient Record System (CPRS).

(c) Chemistry/Hematology Critical Values listed in Policy Memorandum 113-10-08 or current version are to be considered as life threatening to the patient. When these values are encountered, whether requested STAT or routine, the results are verified and the technologist/technician will contact the practitioner who ordered the test. If unavailable, he/she will notify another practitioner on the ward/clinic. In no instance is an RN or ward clerk to be notified.
Name of individual contacted and time will be entered in the computer under comment.

(d) Important findings that require urgent attention will be immediately and directly communicated to the treating practitioner. Findings that may require direct communication and urgent attention include, but are not limited to: (1) Any finding that has the potential to be life threatening or could cause serious harm and that requires an urgent intervention or change in patient management; (2) Any finding that might result in prolongation of patient pain or discomfort; (3) Any finding that would result in the cancellation of on-going or imminent treatment. Direct communication consists of a face-to-face or telephone conversation (or a preliminary note conveyed to the provider according to a specified protocol). Notification and read-back should be accomplished in 30 minutes, or less.

R.14.18 Imaging Tests (See Policy Memorandum 114-07-01 or current version for further instruction):

(a) All Imaging studies to be performed at STVHCS will be ordered electronically. Orders must include a history which clearly demonstrates the appropriateness and urgency of the test requested.
Orders must indicate the ordering practitioner's name, urgency of the study, and accurate contact information.

(b) Results of all imaging studies performed at this facility will be entered and verified in the

Computerized Patient Record System.

(c) Important, unsuspected imaging findings that require urgent attention (new, unsuspected or significantly progressed imaging findings that are life threatening, could cause serious harm or could result in unnecessary discomfort without urgent intervention or change in management) will be immediately and directly communicated to the requesting practitioner or appropriate surrogate. Direct communication consists of a face-to-face or telephone conversation. The time of communication, method of communication, and name of the person contacted will be entered in the study report.

R.14.19 A medical record is determined to be complete when all required contents are assembled and authenticated as previously outlined. All discharge summaries are to be signed by the attending physician. A medical record, which remains incomplete more than 30 calendar days following discharge of the patient, will be considered a delinquent record.

R.14.20 All records are the property of the South Texas Veterans Health Care System, San Antonio, Texas, and can be removed from the premises only under court order, statute, subpoena or conditions consistent with VA regulations.

R.14.21 Staff members, who are chronically delinquent and fail to complete their assignments, including records, will be subject to disciplinary actions according to VA procedures in MP-5, Part II and /or Medical Staff Bylaws. Furthermore, such negligence will become part of the ongoing provider performance evaluation of privileges.

R.14.22 Designated administrative staff will be authorized to make administrative entries as approved by the Chief of Staff. These administrative entries can be for the purposes of: (1) creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering notes to disposition consultation requests and (5) completing other requirements as requested by the Chief of Staff or his/her designee.

SECTION R.15 AUTOPSY (See current version of Policy Memorandum 136-07-11 for further instruction)

R.15.1 Permission to perform an autopsy must be requested in every instance when a patient dies while an inpatient at a VHA facility or under the immediate care of a VHA facility such as during an outpatient or emergency care visit or during an ambulatory care procedure.

R.15.2 The attending physician will be responsible for obtaining permission for autopsy. Requests for permission and completion of authorization to perform an autopsy normally will be made by a physician (preferably the physician responsible for the patient's care) who is fully qualified and prepared to explain the purpose and reasons for the need to perform one.

R.15.3 The Chief, Medical Administration Service (MAS), or designee will be responsible for identifying appropriate next of kin, and ensuring that appropriate consent is obtained.

R.15.4 In cases that have to be reported (all DOA cases, all deaths within 24 hours of admission to the hospital, all traumatic or suspected traumatic deaths i.e., accidents, suicides, or homicides and therapeutic misadventures) to the Medical Examiner's Office, permission for an autopsy should not be asked for until after the Medical Examiner's Office has declined jurisdiction on the case.

R.15.5 The Preliminary autopsy report will be completed and entered into the EMR in 24 hours. The final autopsy report will be completed and entered into the EMR in 30 business days for routine cases and 60 business days for complex cases.

SECTION R.16 INFECTION CONTROL

R.16.1 Hand Hygiene and Isolation Procedures (See Policy Memorandum 111-09-01 Tuberculosis Prevention, 111-09-11 Isolation Precautions, and 111-10-12 Neutropenic Precautions or current version for further instruction): Hand hygiene is the most essential practice to prevent transmission of pathogens. All physicians are required to practice hand hygiene and isolation precautions by policy and patient safety standards. Standard Precautions are blood and body fluid precautions applicable to all patients which are designed to reduce the risk of transmission of pathogens. Respiratory Etiquette, protecting the dispersion of droplets from sneezing or a cough with tissue or some other barrier, is an essential element of standard precautions along with hand hygiene. Transmission-based or Isolation Precautions (Airborne, Droplet, Enhanced Standard, Contact and Enhanced Contact) are used in addition to Standard Precautions to address the transmission of special organisms. Neutropenic Precautions are standard precautions to protect immune compromised patients from exposure to pathogens from fresh fruits, uncooked foods, and live plants and flowers.

R.16.2 Reportable Public Health Conditions **(**See Policy Memorandum 111-08-07 or current version for further instruction): Healthcare providers including the laboratory personnel of the STVHCS shall inform the Infection Control Program of any notifiable condition/disease, either suspect or upon diagnosis. Empiric treatment constitutes necessity to report the condition. The minimum required information for all DSHS reporting includes the patient's name, date of birth, diagnosis, date of onset, treatment and the physicians name may be reported to Infection Control by calling extension 1-5309 (ALMD) at any time or 1-5108 (ALMD) during business hours for all public health illness. Infection Control staff may be reached through the STVHCS information operator for diseases that must be reported IMMEDIATELY to the Texas Department of State Health Services. Healthcare providers are required to report all primary and secondary syphilis diagnoses by telephone to DSHS within one working day of diagnosis and document report in the patient's CPRS medical record. Suspect TB patients should be worked up according Policy Memorandum 111-08-04 Management of Patient on Airborne Precautions to rule out TB and the attached Lung Mass Protocol. Physicians work collaboratively with Infection Prevention and Control to report cases to Public Health.

R.16.3 Prevention of Bloodborne Pathogen Exposures. All health care providers must comply to Policy Memorandum 111-10-10 Prevention of transmission of bloodborne pathogens from health care workers to patients and Policy Memorandum 001-09-21 Procedural response to bloodborne pathogen exposures (or current versions of those policies). If a provider is known to be infected with HIV, HBV, or HCV, he is required to notify the Chief of Staff who will direct the review of the clinical privileges of any exposure prone procedures while maintaining the confidentiality of the health care provider. If a healthcare provider is exposed to blood or other infected body fluid, he is to report immediately to Occupational Health for evaluation and treatment. The healthcare provider is responsible for knowing the infectious status of the source patient and/or obtaining verbal consent and writing orders to test the patient if needed to help determine if antiviral prophylaxis will be recommended.

SECTION R.17 PEER REVIEW : Medical Staff members who are clinical employees and contracted affiliate clinical employees shall participate in the facility protected peer review process as required by their service. All Medical Staff members who are clinical employees and contracted affiliate clinical employees will participate in the service specific clinical pertinence peer review process which provides valuable information for the ongoing professional practice evaluation program. This peer review is not considered as part of the protected peer review program.

SECTION R.18 EDUCATION:

R.18.1 ACLS is required for all Code Blue Team Leaders, anesthesiologists, nurse anesthetists, and LIPs administering, monitoring and/or supervising moderate sedation. All physicians, advance practice nurses, physician assistants, and registered nurses practicing (direct responsibility for patient care) within

Critical Care Areas of CCU, MICU, SICU, PCU, PACU, Emergency Department, Bone Marrow Transplant Unit, Kerrville Urgent Care Center, and Kerrville 5 Medicine. Current staff must meet this requirement within 6 months of publication of policy; new employees must meet this requirement by completion date of unit orientation. Failure to maintain current ACLS training will result in employee's reassignment to a non ACLS area until they are again current in ACLS. Exceptions to BLS or ACLS training will be considered/approved by the Chief of Staff. Note: Consult service providers are excluded from the ACLS training requirement. In PCU, subspecialist attendings (who are not hospitalists) are excluded from the ACLS training requirement.

R.18.2 Continuing Education: All Medical Staff members shall participate in their own individual programs of continuing medical education (CME) or continuing education units (CEU) in order to keep themselves informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care, to refresh various aspects of basic education, and to meet requirements for re-licensure. The minimum requirement for LIP's is 24 CME every two years, or for other medical staff providers, 24 continuing education units (CEU) every two years related to the profession. Medical Staff members are responsible to see that their own participation in continuing education programs and conferences both in and outside the Facility are documented and verifiable at the time of reappraisal and re-privileging.

SECTION R.19 EMERGENCY RESPONSE: Each Service will maintain and distribute to each staff member a recall list for emergency response. Each licensed independent employee will report to his/her area of work and supervisor or designee in the event of an emergency. If the work area and/or supervisor or designee is not accessible, the employee will report to the Medical Staff Unit Leader for further instruction. Each licensed independent employee will function within their current clinical role and approved privileges, unless instructed otherwise by their supervisor or the Operations Chief (Chief of Staff or designee).