MVAHS

MIAMI VA HEALTHCARE SYSTEM

PROUD TO SERVE VETERANS

I CARE

DEPARTMENT OF VETERANS AFFAIRS

BYLAWS AND RULES OF THE MEDICAL STAFF

DATE: DECEMBER 2015

REVIEWED DATE: NOVEMBER 2015

REVISED DATE: NOVEMBER 2015

Table of Contents

PREAMBLE *

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the Miami Veterans Affairs Healthcare System located in Miami, Florida (hereinafter sometimes referred to as MVAHS, Facility, or Organization) hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs, Veterans Health Administration (VHA), and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the VHA, and they do not create any rights or liabilities not otherwise provided for in laws or VHA Regulations.

Miami VA Healthcare System comprises a medical center, multi-specialty outpatient and community based clinics located within the patient service area which include Miami-Dade, Broward and Monroe counties.

Portions of these bylaws are required by the VA, VHA, or The Joint Commission (TJC). These sections should be maintained in accordance with all current regulations, standards or other applicable requirements. Prior versions of bylaws and rules and regulations must be maintained in accordance with Sarbanes-Oxley Act which states that bylaws and rules are permanent records and should never be destroyed. They must be maintained in accordance with Record Control System (RCS) 10-1, 10Q.

DEFINITIONS

For the purpose of these Bylaws, the following definitions shall be used:

1. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, Mid-level and/or patient care services at the facility. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.
2. Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when serving in the capacity of Acting Facility Director.
3. Associated Health Professional: As used in this document, the term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine. These professionals include, but are not limited to: Psychologists, podiatrists, optometrists and audiologists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.
4. Automatic Suspension of Privileges: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or

investigation. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Medical Executive Council.

5. Chief of Staff: The Chief of Staff is the President of the medical staff and Chairperson of the Medical Executive Council and acts as full assistant to the Director in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioners, Advanced Practice Professional, and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of medical staff.
6. Community Based Outpatient Clinic (CBOC): A health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients. A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures
7. Director (or Facility Director): The Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS), the Assistant Director and the Medical Executive Council.
8. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the Facility Director. The Director is responsible for the oversight and delivery of health care by all employees and specifically including the medical staff credentialed and privileged by the relevant administrative offices and facility approved processes.
9. Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the Miami VA Healthcare System to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians and dentists. It may also include individuals who can practice independently, who meet this criterion for independent practice.
10. Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the medical staff process who are subject to the medical staff bylaws. This body may include others, such as retired Practitioners who no longer practice in the organization but wish to continue their membership in the body. The medical staff includes both members of the

organized medical staff and non-members of the organized medical staff who provide health care services.

11. Advanced Practice Professional: Advanced Practice Professionals are those health care professionals who are not physicians and dentists and who will function within a Scope of Practice but may practice independently on defined clinical privileges as defined in these Bylaws. Advanced Practice Professional includes: physician assistants (PA), and advanced practice nurses (ARNP, CRNA, and CRNP). Advanced Practice Professionals may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations, under the supervision of a credentialed and privileged Licensed Independent Practitioner when required. Advanced Practice Professionals do not have admitting privileges and may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations.

12. Associate Director for Patient Care Services, Miami VA Healthcare System: The Associate Director for Patient Care Services is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he is the Chairperson of the Nurse Executive Council (NEC) and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant advanced practice professional and certain associated health staff and in ensuring the ongoing education of the nursing staff.

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

14. Outpatient Clinic: An outpatient clinic is a healthcare site whose location is independent of medical facility, however; oversight is assigned to a medical facility.

15. Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner-specific data collected from various sources for the purpose of evaluating current competence.

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

17. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or

attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.

18. Professional Standards Board: The Professional Standards Board, if established, may act as a Credentials Committee on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matter to the Executive Committee of the Medical Staff as defined in these Bylaws. This board also may act on matters involving Associated Health and Advanced Practice Professionals such as granting prescriptive authority, scope of practice, and appointment. Some professional standards boards (e.g., Nursing, etc.) are responsible for advancement and other issues related to their respective professions.
19. Rules: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the bylaws. They can be reviewed and revised by the Medical Executive Council and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.
20. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider
21. Telemedicine: The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.
22. VA Regulations: The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws. (Example: Code of Federal Regulation (CFR) 38 7402)

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, Miami Veterans Affairs Healthcare System, Miami, Florida which includes all its' locations.

ARTICLE II. PURPOSE

The purposes of the Medical Staff shall be to:

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

2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.
3. Establish and assure adherence to ethical standards of professional practice and conduct.
4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.
8. Provide a medical perspective, as appropriate, to issues being considered by the Director and Governing Body.
9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.
10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.
11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
12. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.
13. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational policy and procedures.
14. Coordinate and supervise the scope of practice of all Advanced Practice Professional and appropriate Associated Health Practitioner staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each Advanced Practice Professional and appropriate Associated Health Practitioner should have a scope of practice statement or privileges as well as the means employed to coordinate and supervise their function with the medical staff.

ARTICLE III. MEDICAL STAFF MEMBERSHIP *

Section 3.01- Eligibility for Membership on the Medical Staff *

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, dentists and other licensed independent practitioners (LIPs) who are doctoral level clinical practitioners (include, but not limited to audiologists, optometrists, podiatrists, psychologists and speech pathologists) who continuously meet the qualifications, standards, and requirements of VHA, this Facility, Resident Supervision in accordance to VHA Handbook 1400.1 and these Bylaws.
2. Categories of the Medical Staff:

A. Active Medical Staff:

(1) Physicians, dentists, and other licensed independent practitioners (LIPs) who are doctoral level clinical practitioners (include but not limited to audiologists, optometrists, podiatrists, psychologists and speech pathologist(s) who are employed at least 4/8's time at the VAHCS.
(2) Members of the active medical staff have voting rights and except for those with administrative responsibilities only, must have delineated clinical privileges.
(3) Active medical Staff are expected to actively participate in appropriate medical staff meetings and activities including committees of the medical staff.
(4) Active Medical Staff are expected to actively participate in Healthcare System performance improvement activities to improve quality of care, treatment, services, and patient safety.

B. Affiliate Medical Staff:

(1) Includes the same professional disciplines as active medical staff but who are employed less than 4/8th s time at the MVHCS, contracted, and employed as WOC or fee basis.
(2) Members of the affiliate medical staff do not have voting rights and except for those with administrative responsibilities only, must have delineated clinical privileges.
(3) Affiliate medical staff may attend staff meetings and may participate in medical staff activities.

C. Associate Medical Staff:

(1) All other practitioners at the MVAHS who are required by the Veterans Health Administration VETPRO program to be credentialed and supplement members of the active medical staff. This would include

but is not limited to advance practice nurses, Physician Assistants, and certified Registered Nurse Anesthetists (Allied Health Professionals).

(2) Associate medical staff who are employed at least 4/8th time at the VAHCS have voting rights.

(3) Associate medical staff, except those with administrative responsibilities only, will have a scope of practice if not privileges.

(4) Associate medical staff with voting rights are expected to actively participate in appropriate medical staff meetings and activities. Other associate medical staff may attend staff meetings and may participate in medical staff activities.

D. Residents – Residents shall consist of professionals who may or may not be licensed to practice medicine, dentistry, podiatry, psychology, and optometry, but who are still engaged in a post graduate training program. Their participation in patient care, education, or research shall be under the appropriate supervision of a Medical Staff member who is licensed to practice medicine, dentistry, podiatry or optometry and who has clinical privileges at the Healthcare System. Residents are not eligible for membership on the active Medical Staff. They may be permitted to serve on designated committees in a non-voting capacity, but shall not be required to attend meetings of the Medical Staff. Mechanisms for supervision of residents are specified in the facility Resident Supervision Policy (141-11-XX) and Monitoring of Resident Supervision Policy (141-12-XX).

E. Students- Students shall consist of physician, dentist, podiatric, optometric or allied health care professionals who may or may not be licensed to practice their profession, but who are still engaged in an accredited training program. Their participation in patient care education or research shall be under the appropriate supervision as outlined by facility policy. Students are not eligible for membership on the Medical Staff. They may be permitted to serve on designated Medical Center committees in a non-voting capacity, but shall not be required to attend meetings of the Medical Staff. Mechanisms for supervision of students are specified in the facility policy on supervision of students (11-114-XX).

F. Other Categories of Medical Staff – Other categories of Medical Staff shall consist of practitioners who are responsible for supplementing the members of the active Medical Staff in their roles in patient care, education, and research. These members shall be appointed to a specific service and shall be permitted to serve on committees but shall not be required to attend meetings of the Medical Staff. They are not eligible for active staff membership. These categories include:

(1) Consultants
(2) On station fee basis, contract or sharing agreement
(3) Without compensation

(4) Intermittent

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

Section 3.02- Qualifications for Medical Staff Membership and Clinical Privileges *

1. Criteria for Clinical Privileges: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial:

   a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required by VA employment and utilization policies and procedures. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine, Osteopathy, or Dentistry from an approved college or university.

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

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

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

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

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

   g. English language proficiency.

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

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

2. Clinical Privileges and Scope of Practice: While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent Practitioners are permitted by this Facility and these Bylaws to practice independently. All Practitioners listed below are subject to the bylaws whether they are granted defined clinical privileges or not.
   a. The following Practitioners will be credentialed and privileged to practice independently:
      i) Physicians
      ii) Dentists
   b. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:
      i) Psychologists
      ii) Audiologists
      iii) Speech Pathologists
      iv) Podiatrists
      v) Optometrists
   c. The following Practitioners will be credentialed and will practice under a Scope of Practice with appropriate supervision:
      i) Advance Practice Nurses
      ii) Physician Assistants
      iii) Certified Registered Nurse Anesthetists
      iv) Clinical Pharmacists (as authorized by Chief, Pharmacy or designee)

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

Section 3.03- Code of Conduct

1. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and

other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being on duty as scheduled. (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

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

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

VA distinguishes Behavior or Behaviors That Undermine a Culture of Safety from constructive criticism that is offered in a professional manner with the aim of improving patient care. VA also reminds its providers of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a provider's health and performance. Providers suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing Behavior or Behaviors That Undermine a Culture of Safety on the part of other providers. VA urges its providers to support their hospital, practice, or other healthcare organization in their efforts to identify and manage Behavior or Behaviors That Undermine a Culture of Safety, by taking a role in this process when appropriate.

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

Section 3.04 - Conflict Resolution & Management

For VA to be effective and efficient in achieving its goals, the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program,* addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. VHA expects VA medical center leadership to make use of these and other resources in communicating expectations to clinicians and other staff that conflictive, disruptive, inappropriate, intimidating, and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff who experience or witness such behavior are encouraged to advise an appropriate supervisor, Service Chief, Chief of Staff or the EEO Manager.

The Medical Staff has the ability to approach the Director for resolution when there is any conflict between the Medical Staff and the Medical Executive Committee.

ARTICLE IV: ORGANIZATION OF THE MEDICAL STAFF *

Section 4.01- Leaders *

1. Composition:
   a. Chief of Staff.
2. Qualifications: Criteria for appointment includes appropriate board certification in the respective specialty and a full-time appointment to the VA.
3. Selection: The Network Director approves recommendations to the position of Chief of Staff. The selecting organization is responsible to complete and submit information on the selectee to the Leadership Management and Succession Sub-Committee (LMSS). The LMSS support staff (Executive Recruitment Team) in the Workforce Management and Consulting Office will submit templates to the Leadership Management and Succession Sub-Committee and Workforce Committee for information only.
4. Removal: All disciplinary and/or adverse actions involving a Chief of Staff position must be referred to the Office of the Accountability Review (OAR). The OAR Employee Relations division will assign an Employee Relations Specialist to work directly with the proposing and deciding officials.
5. Duties:
   a. Chief of Staff serves as Chairperson of the Medical Executive Council.

Section 4.02 - Leadership

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

Section 4.03 - Clinical Services

1. Characteristics: *
   a. Clinical Services are organized to provide clinical care and treatment under leadership of a Service Chief.
   b. Clinical Services hold service-level meetings at least quarterly.
2. Functions: *
   a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety, (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; patient safety and risk management activities; and utilization management.

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

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

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

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

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

g. Annually review privilege templates for each Service and make recommendations to Professional Standards Board.

3. Selection and Appointment of Service Chiefs: Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff. A search committee appointed by the Chief of Staff will review each candidate's qualifications and make recommendations to the Chief of Staff as to the quality of each applicant. Criteria for appointment as Service Chief includes board certification in the appropriate specialty/or equivalent experience and comparable training as vetted through the Professional Standards Board and Medical Executive Council.

4. Duties and Responsibilities of Service Chiefs: * The Service Chief is administratively responsible for the operation of the Service and its clinical and research efforts, as appropriate. In addition to duties listed below, the Service Chief is responsible for assuring the Service performs according to applicable VHA performance standards. These are the performance requirements applicable to the Service from the national performance contract, and cascade from the overarching requirements delegated to the Chief of the Medical Staff. These requirements are described in individual Performance Plans for each Service Chief. Service Chiefs are responsible and accountable for:

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

b. Clinically related activities of the Service.

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

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

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

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

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

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

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

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

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

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

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

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

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

p. The assurance of space and other resources necessary for the service defined to be provided for the patients served.

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

r. Complete and submit the Provider Exit Review form to the Medical Staff Office at the time of inactivation of privileges, including separation from the medical staff, within 7 calendar days of the date of separation, indicating 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.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 - General

1. Committees are either standing or special.

2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.
3. The members of all standing committees, other than the Medical Executive Council, are appointed by the Chief of Staff subject to approval by the Medical Executive Council, unless otherwise stated in these Bylaws.
4. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff.
5. Robert's Rules of Order Newly Revised will govern all committee meetings.

Section 5.02 - Executive Committee of the Medical Staff

1. The Medical Executive Council serves as the Executive Committee of the Medical Staff.

Medical Executive Council Membership: The following are designated voting members:

Voting Members:

Chief of Staff, Chairperson

Deputy Chief of Staff, Vice Chairperson

Associate Chief of Staff/Education

Associate Chief of Staff/Geriatrics & Extended Care

Associate Chief of Staff/Medical Services

Associate Chief of Staff/Mental Health & Behavioral Services

Associate Chief of Staff/Research

Associate Chief of Staff/Surgical Services

Appointed: 2 Members by MEC

Elected: 1 Member by the Medical Staff

Ex-Officio members

Director

Associate Director for Patient Care Services

Chief, Quality Management Service

Integrated Ethics Officer

Chairperson, Professional Standards Board

Voting is limited to physician members only. Other non-voting facility staff may be called upon to serve as resources or attend meetings at the request of the chairperson.

The process for electing one active medical staff member to the MEC is as follows:

1. The medical staff nominates active medical staff members via a paper or electronic ballot.
2. The nominated medical staff member will appear on an electronic voting ballot to be submitted to all medical staff.
3. Upon receipt of the electronic voting ballot, the medical staff is to select one active medical staff member. The member getting the largest number of votes shall be elected.
4. The active or associate medical staff member with the majority of votes will be appointed to the MEC upon the approval of the Director.

The process for removal of a MEC member is as follows:

1. A complaint is filed with MEC or by MEC member or Medical Staff member (i.e. Attendance, Conduct, Adverse Actions against privileges, etc.)
2. A board of inquiry is appointed by COS consisting of 3 voting members of the MEC.
3. A hearing will occur and the board will offer a recommendation.
4. A recommendation requires 2/3 vote by MEC members for approval.

Term of appointment for the three non-permanent members of the MEC will be for two years and consecutive terms are allowed (no more than two consecutive terms)

2. Functions of MEC:

A. Acts on behalf of the organized medical staff between medical staff meetings.

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

C. Acts to ensure effective communications between the medical staff and the Director.

D. Makes recommendations directly to the Governing Body (Director) regarding the:

1) Organization, membership, structure, function and termination of the medical staff;

2) Membership removal/termination before term end will require a 2/3rds vote by the MEC. Member will have appeal rights as outlined in Article VI. Fair Hearing and Appellate Review.

3) Process used to review credentials and delineate privileges for the medical staff;

4) Delineation of privileges for each provider credentialed;

E. Coordination of the ongoing review, evaluation, and improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, the Joint Commission, and relevant external standards.

F. Professional Standards Board (PSB): Oversees process in place for instances of "for-cause" doubt about a medical staff member's competency to perform requested privileges.

G. Oversees process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.

H. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.

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

J. Serves as consultant to executive management and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.

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

L. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.

M. Acts upon recommendations from the PSB.

N. Acts as and carries out the function of the Professional Standards Board which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician.

O. Provides oversight and guidance for fee basis/contractual programs.

Section 5.03 - Professional Standards Board

1. Composition of Board:

   The Professional Standards Board (PSB) will be composed solely of physicians and dentists with other subcommittees including dental, psychology, and other allied professions reporting to the PSB. The Chief of Staff will appoint the Chairperson of the facility Board for appointments and advancements. Members of the facility Board for appointments and advancements will be Chiefs of Service. The Professional Standards Board is a subcommittee of the Medical Executive Council.

2. Board Functions for Medical Staff

   A. Review and act on employment applications and determine whether applicant meets the requirements set forth in VA qualification standards. Sound professional and administrative judgment will be exercised in reviewing applications to ensure that VHA obtains the best qualified personnel. All applicants, following board action, will be informed on the status of their applications. Those who are found ineligible for appointment in VHA will be informed of the reason.

   B. Review completely an individual's qualifications for advancement by an examination of the Official Personnel Folder, Proficiency Reports or performance appraisals, supervisory evaluations, and other pertinent records; and to make recommendations based on their findings.

   C. Conduct probationary reviews for individuals appointed under 38 U.S.C. 4104(l) as outlined in VA Handbook 5005, Part II, Chapter 3.

   D. Execute VA Form 10-2543, Board Action.

   E. Make recommendations to the Under Secretary for Health or designee on appointments and advancements, and on probationary reviews of individuals appointed under 38 U.S.C. 4104(l), which require approval in VHA Headquarters.

   F. Professional Standards Boards may be appointed to determine whether individuals subject to these Bylaws are physically fit for appointment or retention in VA employment. These Boards will consist of a minimum of three physicians, with one member replaced by a representative of the discipline under consideration. A physician will be the chairperson, and the Human Resources Manager will act as a technical adviser. The Board will render its opinion as to whether or not the individual examined can perform the required service satisfactorily without hazard to VA beneficiaries, employees or self.

3. Allied Health PSB for Nurse Anesthetists, Physician Assistants, Advanced Registered Nurse Practitioners, and Clinical Pharmacists functions to review credentials and then make recommendation to the PSB in granting scope of practice for approval of appointment.

4. Selection and Appointment Action

A. The Board will complete the Board Action, VA Form 10-2543, and forward all documents through the approving authority to the Personnel Officer, who will affect the appointment action. For actions that require the approval of the Under Secretary for Health or designee, the facility board will enter its recommendation on VA Form 10-2543, and forward all documentation through channels for approval. On approval, the originals will be returned to the facility.

B. For podiatrists and optometrists, the facility Director will forward the candidate's application and related credentialing documents for consideration and action by a VA National Headquarters Professional Standards Board. On approval by the Under Secretary for health or designee, the original documents and an approved Board Action will be returned to the facility.

5. Applicants Not Recommended for Appointment:

When an applicant is not recommended for appointment, the Professional Board shall record its findings on VA Form 10-2543, and send this form to the approving official. After approval of the Board Action, the applicant will be notified by the Chairperson of the Professional Standards Board in a letter signed by the Chief of Staff or appropriate approving authority that the individual's appointment has not been recommended. The letter will briefly state the basis for the action. The letter should be reviewed by the Human Resources Officer for adherence to technical requirements.

Section 5.04 - Committees of the Medical Staff

1. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Advanced

Practice Professionals and Associated health Practitioners (f) reporting variances to accepted standards of clinical performance by, and in

a. Professional Standards Board
b. Patient Safety
c. Peer Review
d. Pharmacy & Therapeutics Committee
e. Operative & Invasive Committee
f. Infection Control Committee
g. Reusable Medical Equipment Committee

Section 5.05 - Committee Records and Minutes

1. Committees prepare and maintain reports to include data, conclusions, recommendations, responsible person, actions taken, and evaluation of results of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on a quarterly basis.
2. Each Committee provides appropriate and timely feedback to the Services relating to all information regarding the Service and its providers.
3. Each committee shall review and forward to the Medical Executive Committee, a synopsis of any subcommittee and/or workgroup findings.

Section 5.06- Establishment of Committees

1. The Medical Executive Council may, by resolution and upon approval of the Director, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions.
2. The Medical Executive Council may, by resolution and upon approval of the Director, dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

ARTICLE VI. MEDICAL STAFF MEETINGS

1. Regular Meetings: A meeting of the Medical Staff shall be held at least annually. A record of attendance shall be kept.
2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the Medical Executive Council. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (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.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING *

Section 7.01 - General Provisions

1. Independent Entity: Miami VA Healthcare System is an independent entity, granting privileges to the medical staff through the Medical Executive Council and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Advanced Practice Professional and Associated health Practitioner reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff and Advanced Practice Professionals and Associated health Practitioners must practice under their privileges or scope of practice.
2. Credentials Review: All Licensed Independent Practitioners (LIP), and all Advanced Practice Professional and Associated health Practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. All Advanced Practice Professionals and Associated health Practitioners will be subjected to full credentials review at the time of initial appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a maximum period of 2 years.
3. Deployment/Activation Status:
   a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be placed in a "Deployment/Activation Status" and the credentialing file will remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of l994 (USERRA), the Practitioner will update the credentialing file to current status.
   b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the Medical Executive Council through the Professional Standards Board for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.
   c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.

d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care.

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

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

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

5. Initial Focused Professional Practice Evaluation:

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

The evaluation is comprised of six areas of general competencies as established by the by the joint initiative of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties that include:

(1) Patient Care: provides patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

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

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

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

(5) Professionalism: demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding

and sensitivity to diversity, and a responsible attitude toward patients, the medical profession, and society.

(6) Systems-Based Practice: demonstrates an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

Methods for evaluation that may be used are as follows:

- Chart review
- Monitoring of clinical practice patterns
- Simulation
- Proctoring
- External peer review
- Discussion with individuals involved in the care of each patient (e.g., consulting physicians, surgical assistants, nursing or administrative personnel).

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

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

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

6. <u>Ongoing Professional Practice Evaluation:</u>

a. The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the medical staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for medical staff leadership. Each service chief should consider what hospital, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.

i.) Ongoing provider evaluations will be completed semi-annually; however, the Service Chief or the provider can request a provider-specific report at any time. .

ii.) In those instances where a practitioner does not meet established criteria, the service chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.

iii.) The Medical Executive Council of the Medical Staff must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.

iv.) The Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

Section 7.02 - Application Procedures *

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines as set forth in VHA 1100.19. The applicant is bound to be forthcoming, honest and truthful (VHA Directive 1100.19 page 9). To be complete, applications for appointment must be submitted by the applicant on forms approved by the VHA, entered into the internet-based VHA VetPro credentialing database, and include authorization for release of information pertinent to the applicant and information listed below. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the Practitioner says the information provided is factually incorrect.

   A. Items specified in Article III, Section 2, Qualifications for Medical Staff Membership:

      1) Active, current, full and unrestricted license to practice in a state/territory DC. Qualification requirements of 38 U.S.C. Section 7402(f) state that applicants and individuals appointed on or after November 30, 1999, who have been licensed, registered, or certified (as applicable to such position) in more than one State, and are being credentialed for a position identified in 38 U.S.C. Section 7402(b) (other than a Director) are subject to Medical Staff membership revocation for professional misconduct, professional

incompetence, or substandard care by any of those States, or voluntary relinquishment of a license, registration, or certification in any of those States, after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care. (These individuals are not eligible for appointment, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status).

2) Education

3) Relevant training and/or experience.

4) Board Certification/Board Eligibility with completion of an approved residency program.

5) Current professional competence

6) Physical and Mental health status

7) English language proficiency

8) Professional liability insurance (contractors such as fee basis)

9) BLS approved program using criteria by the American Heart Association for all clinically active staff and ACLS for all clinical staff involved in moderate sedation

10) To qualify for moderate sedation and airway management privileges, the practitioner will have specific, approved clinical privileges and will acknowledge that they have received a copy of "The Sedation and Analgesia by Non-Anesthesia Providers" policy and agree to the guidelines outlined in the policy.

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

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

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

1) Name of health care institution or practice
2) Term of appointment or employment.
3) Privileges held and any disciplinary actions taken against privileges, including suspension, revocation, limitations, or voluntary surrender.

E. DEA (Drug Enforcement Administration) registration:
   1) Current or inactive
   2) Previously successful or currently pending challenges to DEA registration or the voluntary relinquishment of such registration

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

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

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

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

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

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

   a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article VIII, Section 8.02.

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

   c. Verification of status of all licenses current and previously held by the applicant.

   d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.

   e. Evidence and verification of board certification or eligibility, if applicable.

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

g. Evidence of registration with the National Practitioner Data Bank (NPDB) Continuous Query Update, for all members of the Medical Staff and those Practitioners with clinical privileges.

h. For all physicians screening will be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner.

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

j. Evidence and verification of the status of any alleged or confirmed malpractice. A signed VA Form 10-0459, Credentialing Release of Information Authorization request from the Practitioner, requesting all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the Practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint. Questions concerning applicants, who may qualify for appointment under the Rehabilitation Act of 1974, will be referred to Regional Counsel.

k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made.

3. The applicant's attestation to the accuracy and completeness of the information submitted.

4. Burden of proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information in 30 days of official written request may serve as a basis for denial of employment consideration.

5. All healthcare providers must submit credentialing information into VetPro as required by VA guidelines.

***NOTE**: Medical Staff appointment does not equate to HR employment. If provider is to also be an employee, the Human Resources appointment process must be followed. Employee appointments can be categorized as Title 38, Title 38 Hybrids, and Title 5 providers.*

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

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

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

Section 7.03 - Process and Terms of Appointment *

1. Chief of Service Recommendation: The Chief of the Service or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met.
2. CMO Review: Credentialing staff will confirm that if the response to the NPDB query displays any of the criteria listed below, the credentials file will be referred to the VISN CMO, prior to presentation to the Executive Committee of the Medical staff, for review and recommendation to continue the appointment and privileging process.

   • Three or more medical malpractice payments in payment history,

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

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

   In order to ensure an appropriate review is completed in the credentialing process and to reduce VHA's liability, a higher level review will be performed by the VISN Chief Medical Officer (CMO) to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Chiefs Approval screen in VetPro as an additional entry recommending appointment in these cases.
3. Professional Standards Board: The Professional Standards Board as a subcommittee of the Medical Executive Council (MEC) recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
4. Medical Executive Council Recommendation: The Medical Executive Council recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

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

6. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or return of the application because of inadequate information.

Section 7.04 - Credentials Evaluation and Maintenance

1. Evaluation of Competence: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the Practitioner applying for clinical privileges has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.

2. Good Faith Effort to Verify Credentials: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The entry will describe the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. It will also indicate when a secondary source, e.g. copy of diploma, confirmation from someone in practice or training at the same time, is being used in lieu of primary-source verification. The applicant should assist in providing required information for this documentation. <***Note:*** *Verification of licensure is excluded from good faith effort in lieu of verification*>

3. Maintenance of Files: A complete and current Credentialing and Privileging (C&P) file including the electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C&P file is the responsibility of the Chief of Staff. Any time a file is found to lack required documentation, without an entry as noted above in paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain the documentation.

4. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a "for-cause" event requiring a focused review.

    a. "Focused" Professional Practice Evaluation will be conducted on all new providers who are new medical staff appointments to the Miami VA Healthcare System that focuses on specific aspects of a practitioner's performance. This is a time-limited process that will be

used when a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization's setting. A focused professional practice evaluation will also be used when a provider requests new clinical privilege(s) or scope(s) of practice or if questions arise regarding a practitioner's professional practice that affects the safety and quality of patient care. 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 requested privilege(s) or scope(s) of practice. The time period for review may be extended if performance issues have not been fully resolved. Information for a focused professional practice evaluation may include:

- Chart review
- Monitoring of clinical practice patterns
- Simulation
- Proctoring
- External peer review
- Discussion with individuals involved in the care of each patient (e.g., consulting physicians, surgical assistants, nursing or administrative personnel).

b. Triggers are single incidents or evidence of a clinical practice pattern that generates a need for performance monitoring. Triggers for a "focused" professional practice evaluation may occur when:

(1) A new employee with clinical privileges or a scope of practice that has credentials to suggest competence, but additional information or a period of evaluation is needed to confirm the new employee's competence in the organization's setting.

(2) An employee has requested a new clinical privilege or scope of practice.

(3) Provider requires supervision for a new procedure or modality to be performed at the Miami VA Healthcare System.

4) Questions regarding a practitioner's competency are raised by:

- Sentinel Event

- Provider –specific tort settlement
- Substantiated practitioner-specific complaint
- Significant safety violation
- Repeated or egregious unprofessional behavior
- Results of peer reviews that raise concerns

e. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the Service's policies and procedures.

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

i) Extension of FPPE review period

ii) Modification of FPPE criteria

iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner)

iv) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported)

5. Ongoing" Professional Practice Evaluation is a process that continuously evaluates a practitioner's professional performance to identify practice issues that may impact quality of care and patient safety. Ongoing professional practice evaluation is an evidence-based privilege renewal process and is part of a decision-making process that will be used on a semi-annual basis to continue a provider's existing privilege(s) or scope(s) of practice, or to limit or revoke existing privilege(s) or scope(s) of practice prior to time of renewal.

Electronic databases may be accessed to assess professional practice related to:

- Review of operative and other clinical procedures performed and their outcomes
- Patterns of blood and pharmaceutical usage
- Utilization of tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Use of consultants
- Performance measures
- Resident Supervision
- Medical record management, etc.

Other information that may be added by the Service Chief to an ongoing professional practice evaluation may be acquired through:

- Periodic and retrospective chart reviews
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient, including consulting physicians, surgical assistants, and nursing and administrative personnel
- Compliance with hospital policies
- Compliance with mandatory training

Section 7.05 - Local/VISN-Level Compensation Panels

Local/VISN-level Compensation Panels recommend the appropriate pay table, tier level and market pay amount for individual medical staff members, as outlined in VA Handbook 5007, Part IX/21. Appointment actions recommended by the Professional Standards Board require a separate review for a pay recommendation by the appropriate Compensation Panel.

ARTICLE VIII CLINICAL PRIVILEGES

Section 8.01 - General Provisions

1. Clinical privileges are granted for a period of no more than 2 years.
2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.
   a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.
   b. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.
   c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Medical Executive Council. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7).

3. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Service Chief
4. Associated Health and Advanced Practice Professionals who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.
5. Requirements and processes for requesting and granting privileges are the same for all Practitioners who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
6. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all Service Chiefs must recommend the practice.
7. Exercise of clinical privileges within any Service is subject to the rules of that Service and to the authority of that Service Chief.
8. When certain clinical privileges are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.
9. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.
10. Teleconsultation: All Practitioners providing teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

Section 8.02 - Process and Requirements for Requesting Clinical Privileges

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.
2. Requests in Writing: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.

3. Credentialing Application: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
   a. Complete appointment information as outlined in Section 2 of Article VI.
   b. Application for clinical privileges as outlined in this Article.
   c. Evidence of professional training and experience in support of privileges requested.
   d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the <Insert name of committee that serves as executive committee of the medical staff>.
   e. A statement of the current status of all licenses and certifications held.
   f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
   g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.
   h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
   i. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association.
4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.
5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and appropriate training/competencies must be documented in accordance with HSPMs 139-04-XX, Airway Management Outside the Operating Room and 139-03-XX, Sedation and Anesthesia Care.

Section 8.03 - Process and Requirement for Requesting Renewal of Clinical Privileges

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

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

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

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

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

e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.

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

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

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

2. Verification: Before granting subsequent clinical privileges, the Credentialing and Privileging Office will ensure that the following information is on file and verified with primary sources, as applicable:

a. Current and previously held licenses in all states.

b. Current and previously held DEA/State CDS registration.

c. NPDB- Continuous Query Registration.

d. FSMB query

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

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

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

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 - Processing an Increase or Modification of Privileges *

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Chief. This request will initiate the re-credentialing process as noted in the VHA Handbook 1100.19.
2. Primary source verification is conducted if applicable, e.g. provider attests to additional training.
3. Current NPDB Continuous Query Registration prior to rendering a decision.
4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Medical Executive Council followed by the Director's/Governing Body's approval.

Section 8.05 - Recommendations and Approval for Initial/Renewal, Modification/Revision of Clinical Privileges

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.
2. The Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.

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

      1. Medical/Clinical knowledge (education competency).
      2. Interpersonal and Communication skills (documentation; patient satisfaction).
      3. Professionalism (personal qualities).

4. Patient Care (clinical competency).
5. Practice-based Learning & Improvement (research and development).
6. System-based Practice (access to care).

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

3. Medical Executive Council, or the committee responsible for the Medical Executive Function, recommends granting clinical privileges to the Facility Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. The Professional Standards Board, a subcommittee of Medical Executive Council, can make the initial review and recommendation but this information must be reviewed and approved by the Medical Executive Council.
4. Clinical privileges are acted upon by the Director within 30 calendar days of receipt of the Medical Executive Council recommendation to appoint. The Director's action must be verified with an original signature.
5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A Copy of approved privileges are given to the Practitioner and are readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.
6. Approval of the scope of practice and prescriptive authority for Advanced Practice Professional and Associate Health Practitioners will follow the same process as previously defined with the Professional Standards Board making initial review and recommendation to the Medical Executive Council for review and approval.

Section 8.06 - Exceptions

1. Temporary Privileges for Urgent Patient Care Needs: Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of an initial appointment for a limited period of time (not to exceed 60 calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff.

a. Temporary privileges are based on verification of the following:

(1) One, active, current, unrestricted license with no previous or pending actions.

(2) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.

(3) Current comparable clinical privileges at another institution.

(4) Response from NPDB Continuous Query Registration with no match.

(5) Response from FSMB with no reports.

(6) No current or previously successful challenges to licensure.

(7) No history of involuntary termination of medical staff membership at another organization.

(8) No voluntary limitation, reduction, denial, or loss of clinical privileges.

(9) No final judgment adverse to the applicant in a professional liability action.

b. A completed application must be submitted within three calendar days of temporary privileges being granted and credentialing completed.

c. A delegated subcommittee of the Executive Medical Council, consisting of at least two voting members of the full committee, recommends appointment to the medical staff.

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

e. Full credentialing must be completed within 60 calendar days of the date of the Director's/Governing Body's signature and presented to the Medical Executive Council for ratification.

2. Emergency Care: Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.

3. Disaster Privileges: As described in the Miami VA Healthcare System Emergency Management Plan, in the event of a disaster and the implementation of the organization-wide disaster management plan, disaster privileges may be approved by the Director upon recommendation by the Chief of Staff.

A. Government-issued photo identification to verify identity, (U.S. passport, state driver's license, or military identification card) and document ID verification; and one of the following:

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

2. Current and active professional license to practice in any state, territory, or commonwealth of the United States or in the District of Columbia;

3. Primary source verification of the license;

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

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

6. Identification by current hospital or medical staff member(s) for Licensed Independent Practitioner or non-Licensed Independent Practitioner who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner or AHP during a disaster.

B. Oversight of the performance/competency of the volunteer licensed independent practitioner who are granted disaster privileges will be done by the applicable Service Chief or Section Chief in the area of the volunteer's (sub) specialty. Such oversight may include direct observation, mentoring, retrospective review, and concurrent clinical collaboration in the care of disaster victims. The facilitating LIP medical staff member will facilitate collaboration in the care of disaster victims. The facilitating LIP will conduct direct observation to ensure the care, treatment, and services provided by a volunteer LIP and/or AHP meet the quality standards set by the Medical Staff of the MVAHS. Based on the Chief of Staff's recommendation and/or information obtained regarding the professional practice of the volunteer, the Director will make the decision within 72 hours related to the continuation of the disaster privileges initially granted.

C. Volunteers will be distinguished with temporary identification badges (Temporary Privileges – Physician" and may include the subspecialty) and "start and end dates," also "Temporary

Responsibilities/Privileges" for non-LIP staff) and include start and end dates.

D. Photocopies of the above listed documents will be made and retained in the Medical Staff office. Primary source verification of licensure as soon as the immediate situation is under control, and is completed within 72-hours from the time the volunteer practitioner presents to the Miami VA. In the event that primary source verification cannot commence or be completed within such time frame, it shall be accomplished as soon as reasonably practicable thereafter. In such event, there will be documentation in the provider's Credentialing and Privileging folders of why primary source verification could not be timely accomplished and evidence of a documented ability to provide adequate care, treatment and services by such individual granted disaster emergency privileges initially granted for 72-hours of such appointment. Verification of all other information per VHA Handbook 1100.19 will be conducted as soon as possible by the Medical Staff office personnel.

E. Temporary disaster privileges and/or responsibilities shall be granted to an appropriately qualified practitioner, based on the needs of the MVAHS to augment staffing due to a disaster situation. The Director handling the disaster situation shall approve privileges on the recommendation of the Chief of Staff. Approvals will be documented in writing.

F. Upon approval, Police Service will be notified and will issue a temporary identification badge to appropriate practitioners. The Chief, Police Service, is responsible for ensuring that a log is kept of the identification badges issued and that all temporary identification badges are returned to Police Service when the disaster situation ends.

G. The volunteer practitioner will be assigned to a current LIP medical staff member to facilitate collaboration in the care of disaster victims. The facilitating LIP will conduct direct observation to ensure the care, treatment, and services provided by a volunteer LIP and/or AHP meet the quality standards set by the Medical Staff of the MVAHS. Based on the Chief of Staff recommendation and/or information obtained regarding the professional practice of the volunteer, the Director makes the decision within 72-hours related to the continuation of the disaster privileges initially granted.

H. In the event that verification of information results in adverse information about the qualifications of the practitioner, privileges

will be immediately terminated. Temporary disaster privileges and/or responsibilities are not to exceed 60 days.

l. When the Director declares that the disaster period is over, the Chief of Staff will direct the Medical Staff Specialist to notify all practitioners with temporary disaster privileges and/or responsibilities that those privileges and/or responsibilities are no longer needed. Administrative termination of disaster privileges and/or responsibilities in good standing will not be adverse to the practitioner's record.

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

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

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

5. Deployment and Activation Privilege Status: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment.

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

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

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

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

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

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

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

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

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

(2) Registration with the NPDB Continuous Query with no match.

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

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

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

Section 8.07 - Medical Assessment

A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an

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

ARTICLE IX - INVESTIGATION AND ACTION

1. Concerns Identified: Whenever there are concerns that a Practitioner has demonstrated substandard care, professional (clinical) misconduct, or professional (clinical) incompetence, further information will be gathered to either confirm or refute the legitimacy of the concerns. The individual's immediate supervisor will typically be the individual responsible for conducting a preliminary review of the alleged clinical deficiencies to determine whether a comprehensive focused clinical care review or other administrative review is warranted. The Service Chief of the Practitioner's clinical service, the Chair of MEC, the Chief of Staff or the Medical Center Director may also initiate a preliminary fact-finding.

2. Documentation: Whenever a preliminary fact finding confirms a concern considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Behavior or Behaviors that Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, further review of the concerns may result in a fact-finding, administrative investigation, or comprehensive focused clinical care review. These findings may result in an administrative action.

a. Material that is obtained as part of a protected performance improvement activity (i.e., 38 U.S.C. 5705) may not be used to support an administrative action although performance improvement data, such as that obtained as a result of an Ongoing Professional Practice Evaluation (OPPE), may trigger a more comprehensive review of the Practitioner's work.

b. Quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705. Therefore, if such information is necessary in order to conduct a review of the alleged professional deficiencies and any action resulting from the review, it must be developed through mechanisms independent of the performance improvement program, such as a fact-finding, a comprehensive focused clinical care review, an administrative investigation, etc.

3. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care due to the potential of imminent danger to the health and well-being of an individual,

including the Practitioner, to summarily suspend all or a portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Medical Center Director. The typical process to be followed in order to summarily suspend a Practitioner's privileges is as follows (for information about the Automatic Suspension of Privileges, see paragraph 6 below):

a. The Chief of Staff will make a recommendation to the Medical Center Director that a summary suspension of all or part of the Practitioner's privileges be invoked because the failure to take such action may result in an imminent danger to the safety and welfare of an individual.

b. The Medical Center Director will approve the request, if appropriate, and the Practitioner will be issued a notification letter that all or part of the Practitioner's clinical privileges are suspended and include the general reason that the action being taken. This notice will also include information in regards to the requirement to report the individual to the National Practitioner Data Bank (NPDB) if the Practitioner should retire or resign prior to the conclusion of the clinical review and any action resulting from those findings being imposed. (***NOTE:*** Management's decision to take a Practitioner out of patient care or place a Practitioner in an authorized leave status due to patient care concerns will result in a summary suspension of clinical privileges being imposed as the underlying reason for such action is due to concerns about the imminent danger to the health or well-being of an individual, and a summary suspension of clinical privileges letter must be issued to the Practitioner immediately.)

c. Immediately upon the imposition of a summary suspension, the Service Chief or the Chief of Staff will ensure that alternate medical coverage for the Practitioner's patients is provided.

d. The written notification of summary suspension of clinical privileges affords the Practitioner of the opportunity to submit, within14 calendar days from receipt of the summary suspension notification letter, a written response to the concerns identified within the letter.

e. Upon receipt of the Practitioner's written response, the Medical Center Director will determine whether or not the summary suspension of privileges should continue to be imposed pending the outcome of the comprehensive clinical review and any further action imposed as a result of the review. If the decision is made to continue the summary suspension of privileges, the Practitioner's response to the identified issues will be shared with the individual(s) conducting the review of the clinical concerns.

4. <u>Review Process:</u>

a. When sufficient evidence exists, based on the preliminary fact finding, that a Practitioner may have demonstrated substandard care, professional

misconduct or professional incompetence that impacts the Practitioner's ability to deliver safe, high quality patient care, the Chief of Staff will normally appoint one or more impartial clinical care reviewers to complete a comprehensive focused -clinical care review of the concerns(s) or issues(s).

b. The Chief of Staff will determine the appropriate methodology and membership for conducting a review. The individual(s) tasked with performing this review must conduct it in a fair and objective manner, and may be selected from the Practitioner's facility or another facility at the discretion of the Chief of Staff and/or Medical Center Director.

c. If the Practitioner is not summarily suspended as indicated in paragraph 3 of this Part, the Practitioner will be issued a letter notifying the Practitioner that if he/she resigns or retires while the review is being conducted, the Practitioner may be reported to the National Practitioner Data Bank (NPDB).

d. The individual(s) who are conducting the comprehensive focused clinical care review have the discretion to meet with the Practitioner to discuss or explain the clinical care concerns. This meeting does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation initiated at the direction of the Chief of Staff is an administrative matter and not an adversarial Hearing. A record of such meeting is made and included with the reviewers' findings, conclusions and recommendations reported to the MEC.

e. The comprehensive focused-clinical care review is typically completed within 30-calendar days but may be extended if circumstances warrant a longer review period. Documentation in support of an extension should be maintained, and the Practitioner should be notified on regular intervals of the status of the review and the Practitioner being investigated will be apprised of the extension.

f. The reviewer(s) may review any documentation needed to fully assess the issues (except for those exempt in paragraph 2 above) and/or interview witnesses, including the Practitioner, at their discretion.

g. The report of the comprehensive focused clinical care review will be made to the *MEC* within *14 days* after the reviewers have completed the investigation. The *MEC* will assess the results and make a recommendation to the Medical Center Director regarding the appropriate action to be taken. The *MEC* has the discretion to meet with the Practitioner within 10 calendar days after receipt of the evidence to ask him/her questions about the findings before reaching a conclusion regarding their recommendations. The *MEC* is not required to meet with the Practitioner, and if the Practitioner fails to meet with the *MEC* within a

reasonable period of time, which is typically 14 days calendar days after the meeting is requested, the MEC must submit its recommendation for action without the Practitioner's input. This proceeding does not constitute a hearing, and there is no entitlement to any procedural rules set forth in Article X of these Bylaws or any other VA regulations. The *MEC* is not required to share the report or any supporting documentation in advance of the proceeding or during the proceeding with the Practitioner. A record of such proceedings will be made and included with the reviewers' findings, conclusions and recommendations that are submitted to the Director.

5. Recommendations Following the Review:

a. The *MEC* can make the following recommendations to the Director based on the evidence gathered before, during and after the review:

i. No action;
ii. Initiation of a Focus Peer Performance Evaluation (FPPE);
iii. Revocation of privileges; or
iv. Reduction in privileges.

b. Within five (5) business days, the Medical Center Director will review the recommendation of the *MEC* and forward it to the Chief of Staff for appropriate administrative action, if applicable.

c. No action: If the Medical Center Director concurs with the *MEC's* recommendation for no action, the Practitioner will be notified in writing within five calendar days and, if applicable, be notified that privileges are restored.

d. FPPE:

i. If the recommendation is for an FPPE to be initiated, privileges will be reinstated upon the creation and issuance of the FPPE. The FPPE will provide appropriate notification to the Practitioner of the areas of weakness and develop a plan under which the Practitioner can improve in order to successfully complete the FPPE and demonstrate the requisite skill and knowledge in those areas of clinical issues identified as a concern. (***NOTE:*** An FPPE will normally be for a minimum of 60-calendar days. In general, extension of the FPPE is discouraged.)

ii. Upon completion of the FPPE, results will be reported back to the *MEC.*

e. Revocation of Privileges:

i. If the MEC recommends that the Practitioner's privileges be revoked,

or if a Practitioner fails an FPPE and the *MEC* subsequently recommends the revocation of privileges, the Chief of Staff will assess the evidence and coordinate the separation of the Practitioner with Human Resources Management Service, unless management offers the practitioner a position at the facility that does not require the Practitioner to have clinical privileges.

ii. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed removal and proposed revocation of privileges in accordance with VA Handbook 5021, Part II, unless other separation procedures under VA Handbook 5021, Part VI are applicable. If the Practitioner is separated and the Practitioner's privileges are revoked for issues involving professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board, if applicable.

iii. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a)(1), the Medical Center Director will issue a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of the right to a fair hearing after the separation is imposed in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

iv. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the procedures in VA Handbook 5021, Part III will be followed unless other separation procedures under VA Handbook 5021, Part VI are applicable. If the Practitioner is separated following these procedures, the Practitioner will be afforded the opportunity for a fair hearing after the separation is imposed in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

v. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for revocation of clinical and privileges and need to remove the Practitioner from the facility. The Practitioner will be separated and subsequently be notified of the right to a fair hearing after separation in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will

not serve as an appeal to be reappointment to the medical center.
appeal to be reappointment to the medical center.

d. Reduction of Privileges:

i. If the *MEC* recommends that the Practitioner's privileges be reduced, or if a Practitioner fails an FPPE and the *MEC* subsequently recommends the reduction of privileges, the Chief of Staff will assess the evidence and coordinate the reduction of the Practitioner's privileges with Human Resources Management Service.

ii. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed reduction of privileges and proposed reduction in grade or basic pay in accordance with VA Handbook 5021, Part II, if the Practitioner's change in privileges will result in a reduction in grade or basic pay. If the Practitioner's grade or basic pay and privileges are reduced for issues involving professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board.

iii. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a)(1), the Medical Center Director must determine if the Practitioner's services are still needed given the reduction in privileges.

a. If it is determined that the Practitioner's services are still needed, management will follow the procedures for modifying a Practitioner's privileges.

b. If the Practitioner's services are no longer needed then the Practitioner will be issued a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of right to a fair hearing after separation in accordance with Article X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

iv. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the Practitioner may be assigned to duties that do not require a reduction in privileges or the procedures in VA Handbook 5021, Part III will be followed, unless other separation procedures under VA Handbook 5021, Part VI are applicable. (***NOTE:*** Probationary employees cannot be issued a major adverse action, and thus a suspension, transfer of function, reduction in grade or basic pay is not an option.) If the Practitioner is

separated, he/she will be afforded the opportunity for a fair hearing after separation in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

v. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for reduction of clinical and privileges. If the Practitioner's services are no longer needed, the Practitioner will be separated from the contract and subsequently be notified of the right to a fair hearing after separation in accordance with Part X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation from the contract is for substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. If it is determined that the Practitioner's services are still needed, management will notify the Practitioner of the right to a fair hearing of the reduction of clinical privileges in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the reduction are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB.

6. Automatic Suspension of Privileges:

a. An automatic suspension of privileges occurs immediately under the occurrence of an event that may include, but is not limited to, the following:

i) The Practitioner is being investigated, or was indicted for a misdemeanor or felony. The privileges may only be reinstated after the outcome of the legal issue is finalized and after a determination is made regarding the nexus between the legal issue and the mission of VA.

ii) The Practitioner is being investigated for conduct or behavior issues that do not have an impact on patient care but management has determined it could negatively impact the work environment.

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

iv) The Practitioner fails to maintain the mandatory requirements for Membership to the medical staff.

b. Immediately upon the imposition of an automatic suspension, the Service Chief or the Chief of Staff will ensure that alternate medical coverage for the Practitioner's patients is provided.

c. The Medical Center Director may initiate an appropriate review of the concern(s) or issues(s) resulting in the automatic suspension to include recommendations for appropriate administrative action.

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

7. Actions Not Constituting Corrective Action: The comprehensive clinical care reviewers responsible for conducting reviews are not deemed to have proposed an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a hearing under Article X or a Disciplinary Appeals Board (DAB) will not have arisen in any of the following circumstances:

a. The appointment of an ad hoc investigation committee;

b. The conduct of an investigation into any matter;

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

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

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

f. Corrective counseling;

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

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

ARTICLE X - FAIR HEARING AND APPELLATE REVIEW

1. Reduction of Privileges:

a. Prior to any action or decision by the Director regarding reduction of privileges, that does not also involve a major adverse action, such as a suspension, reduction in grade, or reduction in basic pay, as defined in VA Handbook 5021, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

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

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

b. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff's written notice of intent. The Practitioner must submit a response within l0 workdays of the Chief of Staff's written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed l0 additional workdays except in extraordinary circumstances.

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

d. A proposed action taken to reduce a Practitioner's privileges will be made in accordance with VHA Handbook 1100.19. In instances where reduction of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code, the proposed reduction of privileges will be combined with a major adverse action (e.g. suspension, reduction in basic pay, reduction in grade, transfer, etc.) in accordance with Section 7461 7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations. ***NOTE:*** A major adverse action may not be proposed against a 38 U.S.C. Section 7403 or Section 7405 (except nurses) employee, or a contractor.

2. Convening a Panel:

a. A panel is not convened if a reduction in clinical privileges is combined with a major adverse action, such as a suspension, reduction in grade, or a reduction in basic pay, due to substandard care, professional misconduct or professional incompetence. A reduction in basic pay may occur when a physician's salary is reduced by a pay panel as a result in a reduction in privileges. In those instances, the proposed reduction and proposed major adverse action are taken together in accordance with the provisions of VA Handbook 5021, Part II.

b. In the case of a reduction in clinical privileges that does not constitute a major adverse action or is not combined with a major adverse action in accordance with VA Handbook 5021, the facility Director must appoint a review panel of at least three unbiased professionals, within 5 business days after receipt of the Practitioner's request for a hearing. These professionals will conduct a review and hearing. At least two members of the panel must

be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

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

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

a) Be present throughout the evidentiary proceedings;.

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

c) Cross-examine witnesses.

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

3. The panel must complete the review and submit the report within 15 business days from the date of the close of the hearing. The panel may request in writing that the facility Director grant additional time due to extraordinary circumstances or cause.

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

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

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

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

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

4. The hearing panel chair shall do the following:

a. Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.

c. .Maintain decorum throughout the hearing.

d. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.

e. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.

f. Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.

g. Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

5. <u>Practitioner's Rights:</u>

a. The Practitioner has the right to be present throughout the evidentiary

proceedings, represented by counsel or a representative of Practitioner's choice, (provided that this representative does not have a conflict of interest) cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

b. The Practitioner may submit a written appeal to the VISN Director within 5 business days of receipt of the Director's decision, if he/she is in disagreement with the decision rendered.

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

6. Revocation of Privileges:

a. Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures in accordance with VHA Handbook 1100.19, and following regulations are applicable:

i) In instances where revocation of privileges is proposed for permanent employees, appointed under Section 7401(1) of Title 38 United States Code, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations.

ii) For probationary employees appointed under 38 U.S.C. 7401(1) and Part time temporary registered nurses appointed under 38 U.S.C. 7405, the Professional Standard Board (PSB) will convene in accordance with the procedures outlined in VA Handbook 5021, Employee/Management Relations. If separation is recommended and the recommendation from the PSB is based in whole, or in part, for reasons of substandard care, professional incompetence, or professional misconduct, the Director, or designee, may separate the Practitioner as prescribed in VA Handbook 5021. Separation constitutes an automatic revocation of clinical privileges, which is reportable to the NPDB, if the Practitioner is a physician or dentist, but only after being afforded due process. All practitioners, whether reportable to the NPDB or not, are entitled to due process. Refer to Article X, Section 10.01, para 2 for due process procedures.

iii) In instances where the Practitioner is appointed through a contract or other "at will" appointment, including but not limited to part-time (excluding part-time temporary registered nurses who are covered under the procedures in para 5(a)(ii), fee basis, without compensation, or intermittent appointment, separation may occur immediately, but separation constitutes an automatic revocation of clinical privileges and is reportable to the NPDB if the Practitioner is a physician or dentist, and the revocation is for substandard care, professional incompetence, or professional misconduct. A report to the NPDB may not be filed until all due process has been exhausted. Refer to Article X, Section 10.01, para 2 for due process procedures.

b. Revocation procedures will be conducted in a timely fashion. Revocation of clinical privileges may not occur unless the Practitioner is also discharged, separated during probation, or the appointment is terminated. However, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the Practitioner is a physician or dentist and the revocation of privileges and subsequent reassignment constitutes a major adverse action due to a reduction in grade or basic pay, is for reasons of substandard care, professional incompetence, or professional misconduct (e.g., a surgeon's privileges for surgery may be revoked, and the surgeon may be reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility). Any recommendation by the MEC for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X, section 10.01, para 2 of these Bylaws.

7. Reporting to the National Practitioner Data Bank[1]:

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

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

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

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

e. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physician and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4 The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be

reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension if greater than 30 days will be reported.

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

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

ARTICLE XI - RULES AND REGULATIONS

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

ARTICLE XII - AMENDMENTS

1. The Bylaws and Rules are reviewed at least annually and revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws and Rules and attendant policies may be submitted in writing to the Chief of Staff by any Service Chief or member of the Medical Staff. Recommendations for changes come directly from the Medical Executive Council. Such changes and will be effective when approved by the Director. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given

30 days to review proposed changes, vote upon them and are notified of the date that proposed changes are to be considered.

2. The Medical Executive Committee may provisionally adopt and the Director may provisionally approve urgent amendments to the Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the medical staff. After adoption, these urgent amendments to the Rules and Regulations will be immediately communicated back to the Organized Medical Staff for retrospective review and comment on the provisional amendment. These changes will be communicated electronically. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.04 should be followed.

3. All changes to the Bylaws require action by both the Medical Staff and Director. Neither may amend unilaterally.
4. Changes are effective when approved by the Director.

ARTICLE XIII - ADOPTION

These Bylaws, together with the appended Rules, shall be adopted upon recommendation of the Medical Staff at any regular or special meeting of the Medical Staff or by electronic vote of the Medical Staff. They shall replace any previous Bylaws and shall become effective when approved by the Director.

RECOMMENDED

Vincent DeGennaro, M.D. — Date: 1/10/16

Chief of Staff

Miami VA Healthcare System

APPROVED

Paul M. Russo, MHSA, FACHE, RD — Date: 1-27-16

Director

Miami VA Healthcare System

MEDICAL STAFF RULES

1. GENERAL

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

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

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

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

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

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

2. PATIENT RIGHTS

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

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

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

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

iv) Pain management including assessment, treatment and education.

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

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

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

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

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

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

xi) Personal privacy and confidentiality of information.

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

xiii) Authority of Chief of Staff to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available).

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

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

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

i) Competent patients have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.

ii) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with, as appropriate, other members of the treatment team (38 USC sections 7331).

iii) With respect to the documentation of decision making concerning life-sustaining treatment, the following information, at a minimum, will be documented in the progress notes by the attending physician: The patient's diagnosis and prognosis; an assessment of the patient's decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.

iv) Competent patients will be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning

life-sustaining treatment will be honored, and will be documented in the medical record.

v) Advance Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any competent patient may execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a patient at any time.

vi) Substituted Judgments: The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:

(a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.

(b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.

(c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or

withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the attending physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body, or Chief of Staff.

3. RESPONSIBILITY FOR CARE

A. Conduct of Care

i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff.

(a) The attending Staff Physician is responsible for the preparation and completion of a complete medical record for each patient. This record shall include a medical examination, an updated problem list, identification data, chief complaints, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathological findings, progress notes, doctor's discharge instructions sheet, including condition on discharge (discharge note) and final diagnosis, and final summary.

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

Medical Assessment of the patient shall include:

a. Medical history, including:
   1. Chief complaint
   2. Details of present illness
   3. Relevant past, social and family history
   4. Inventory by body system, including pain assessment
   5. Summary of the patient's psychological needs

6. Report of relevant physical examinations
7. Statement on the conclusions or impressions drawn from the admission history and physical examination
8. Statement on the course of action planned for this episode of care and its periodic review
9. Clinical observations, including the results of therapy.

(c) The staff physician responsible for the patient must sign the admission note if it is prepared by a resident, intern, or Advanced Practice Professional, or make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" or make whatever comments he/she thinks the case warrants, or prepare a complete admission within forty eight (48) hours of admission to the CLC. In the event a resident, intern, or Mid-Level Practitioner prepares an admission workup, all will be retained, but the official workup will contain the responsible Medical Staff physician's approval signature. All resident documentation will follow procedures outlined in the VHA Handbook 1400.1, Resident Supervision.

(d) Food and nutrition products are administered only on the prescription or order of a Medical Staff member, an authorized house staff member, or other individual who has been granted authority to write such prescriptions or orders, within their scope of practice.

(e) Progress note entries should be identified as to the type of entry being made, (e.g., Resident Note, Attending Note, Off Service Note, etc.). The Attending Note must be signed by the Attending physician.

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

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

(h) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written or, at minimum, countersigned by the attending physician in the patient's medical record. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility

of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the Facility staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.

(ii) Patients will not be transferred out when the Facility has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer only after authorization is given by the appropriate provider as defined in facility policy.

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

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

B. Consultations:

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

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

(b) The diagnosis is obscure; and/or

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

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

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

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

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

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

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

ii) Discharge planning is documented in the medical record.

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

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

D. Discharge

i) Patients shall be discharged from the MVAHS only upon the written order of the physician and the discharge summary will be completed (signed) and available for review in CPRS within 2 business days of discharge from the inpatient setting and 3 business days for CLC residents. At time of completing the final summary, the responsible member of the Medical Staff shall review the medical record to ensure that documents therein pertain to the patient and contain accurate data. The record shall be completed within thirty (30) days of the discharge of the patient. The physician or dentist shall complete his/her portion of the record within thirty (30) days, including authentication.

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

E. Autopsy

i) Autopsy services are provided by Pathology & Laboratory Medicine Service. The availability of these services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within the Facility.

ii) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-170. Whenever possible, the physician responsible for the care of the patient at the time of death will be designated to request permission from the next of kin to perform an autopsy.

iii) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.170, VHA Handbook 1106.01 and MVAHS HSPM 113-03-xx – Criteria for a Medical Autopsy.

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

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

management purposes as described in 38 CFR 17.170, VHA Handbook 1106.01 and MVAHS HSPM 113-03-xx – Criteria for Medical Autopsy. Those cases meeting criteria as Medical Examiner's cases per policy will be referred to the appropriate County Medical Examiner's Office in accordance with state statutes.

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

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

4. PHYSICIANS' ORDERS

A. General Requirements

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

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

iii) Telephone orders will be accepted when the provider is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS. They will be accepted by Registered Nurses, Pharmacists, Physician Assistants, Advanced Practice Registered Nurses, Certified Registered Nurse Anesthetists, etc. as designated by facility policy and when it clearly is in the best interest of patient care and efficiency. Appropriate staff receiving the order telephonically will first write down the verbal order and read back the order to the physician to ensure correctness. Verbal/telephone orders will be entered by the nurse or pharmacist and signed electronically by the physician within 24-hours or the next working day whichever is earlier.

B. Medication Orders

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

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

iii) Duration of Orders:

(a) Schedule II controlled drugs will be written for periods not to exceed fourteen (14) days for in-patients and must be reentered by

electronic entry into EMR for each succeeding period of 14 days or less.

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

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

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

iv) Ambulatory Care Medication Orders:

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

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

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

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

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

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

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

E. Informed Consent:

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

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

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

G. Special Treatment Procedures:

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

(a) A description of the role of the physician, family members and when applicable, other staff in decision.

(b) Mechanisms for reaching decisions about withholding of resuscitative services, including mechanisms to resolve conflicts in decision making.

(c) Documentation in the medical record.

(d) Requirements are described in Facility Policy Memoranda, Medical Staff Bylaws, and these Rules.

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

5. ROLE OF ATTENDING STAFF - (Resident Supervision Policy – 141-11-XX; Monitoring of Resident Supervision -141-12-xx; Supervision of Students – 141-XX-XX)

A. Supervision of Residents and Non-Physicians

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

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

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

B. Documentation of Supervision of Resident Physicians

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

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

(a) Medical history and physical examination.

(b) Discharge Summary.

(c) Operative Reports.

(d) Medical orders that require co-signature.

(1) DNR.

(2) Withdrawing or withholding life sustaining procedures.

(3) Certification of brain death.

(4) Research protocols.

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

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

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

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

6. MEDICAL RECORDS

***NOTE**: For additional information see:*

http://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=3088

A. Basic Administrative Requirements:

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

ii) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Advanced Practice Professionals.

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

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

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

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

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

B. All Medical Records must contain:

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

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

iii) Observations, including results of therapy.

iv) Diagnostic and therapeutic orders.

v) Reports of procedures, tests and their results.

vi) Progress notes.

vii) Consultation reports.

viii) Diagnostic impressions.

ix) Conclusions at termination of evaluation/treatment.

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

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

i) A history that includes chief complaint, history of present illnesses, childhood illnesses,, adult illnesses, operations, injuries, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, chief complaint, and review of systems;

ii) A complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self-care, mentation, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient assessed personal history. Key examination medical impressions will be documented in the note. The note must be authenticated by provider at the earliest possible time, but always within 24 hours of being written in CPRS.

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

(b) Inpatient H&P must be completed within 24 hours, 72 hours for Community Living Center (CLC) 48 hours for long care; and 7 days for the Domiciliary

iii) A discharge plan (from any inpatient admission or Domiciliary), including condition on discharge.

iv) Have a discharge summary (signed) (from inpatient or Domiciliary) available for review in CPRS within 2 business days of discharge from the inpatient setting and 3 business days for CLC residents.

v) Completed within 30 days of discharge.

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

i) A progress note for each visit.

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

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

iv) Immunization status, as appropriate.

v) Allergies.

vi) Referrals and communications to other providers.

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

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

E. Surgeries and Other Procedures:

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

ii) Preoperative Documentation:

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

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

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

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

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

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

(1) Pre-operative diagnosis,

(2) Post-operative diagnosis,

(3) Technical procedures used,

(4) Surgeons,

(5) Findings,

(6) Specimens removed, and

(7) Complications.

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

(1) Anesthesia,

(2) Drains,

(3) Tourniquet Time, or

(4) Plan.

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

v) Post Anesthesia Care Unit (PACU) Documentation:

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

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

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

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

7. INFECTION CONTROL – Reference HSPM 11-10-XX

A. Isolation is described in Infection Prevention and Control Policy.

B. Standard Precautions are described in Infection Prevention and Control Policy.

C. Reportable Cases are described in Infection Prevention and Control Policy.

8. CONTINUING EDUCATION

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

9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

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

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

B. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the Employee Assistance Program or the Physician Recovery Network Program of the Florida Medical Association and monitoring program.

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

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

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

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

10. PEER REVIEW

A. The peer review process is intended to promote a confidential and systematic method that contributes to quality management efforts at the individual provider level, within a non-punitive context. It can also be conducted to assess resource utilization issues related to individual provider decisions. Although organizational issues are sometimes identified, the primary goal is overall improvement in the care provided to veterans through a review of individual provider decisions.

B. Protected peer review done for quality management and/or resource utilization purposes fosters a responsive environment where issues are identified, acted upon proactively, and in ways that continually contribute to the best possible outcomes and strong organizational performance. Peer review is intended to be an endeavor encompassing multiple disciplines requiring active involvement from physicians, nurses, and other licensed staff. The peer review process consists of an initial review conducted by an individual clinical peer reviewer followed by a secondary review by the facility Peer Review Committee (PRC)

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

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

11. EMERGENCY SERVICES

A. This Medical Center's emergency services are designated at level III using Joint Commission definitions of Levels I, II, III or IV, and an accredited Chest Pain Center by the Society of Chest Pain Centers. Emergency Services are available 24-hours per day, 7-days per week. The physician staffing level and qualifications are consistent with the level of services provided. Specialty consultations are available through the on-call system; rosters are available in the emergency room.

B. This Medical Center will provide reasonable care in determining whether an

emergency exists, will render lifesaving care, admit patients to inpatient status or make the appropriate referral to the nearest medical facility capable of providing the needed services.

C. Patients presenting with life-threatening conditions will receive the highest priority and will be evaluated and treated immediately. Patients with non-emergent conditions will be evaluated and treated as soon as possible after arrival.

D. Emergency care will be provided to all eligible veterans and those individuals requiring emergency care on a humanitarian basis i.e. acutely ill or injured employees, visitors or volunteers.

12. CPR CERTIFICATION (BLS and/or ACLS) – Reference HSPM 111-15-XX

A. BLS Certification. BLS certification is required for all licensed independent practitioners (LIP), advanced practice nurses, and physician assistants.

B. ACLS Certification. ACLS certification is required for:

a. Staff that order, administer, monitor, or supervise moderate sedation, monitored anesthesia care, or general anesthesia.
b. Privileged LIPs that are assigned to code teams, and nurses who work in the following high risk or critical areas:
    a. Intensive Care Units (medical and surgical);
    b. Coronary Care Units, Step-down Units;
    c. Telemetry Units;
    d. Post-operative recovery areas or units;
    e. Emergency Departments;
    f. Procedure rooms:
        *Cardiac Catheterization Laboratories
        *Electrophysiology Laboratories;
        *Interventional Radiology Laboratories;
        *Gastroenterology Endoscopy Laboratories
        *Dental Suites. ACLS is only required for those dental providers administering moderate sedation or general anesthesia.

2. Any provider, including the Medical Officers of the Day that would be required to serve as a "Code Leader."

All providers are required to maintain their BLS and/or if required, ACLS, current and valid at all times.

13. DISCLOSURE – HSPM 00-110-XX

A. Miami VA Healthcare System and its providers have an ethical and legal obligation to disclose adverse events sustained in the course of veterans' care to patients or their personal representatives. These disclosures include

cases where the adverse event may not be obvious or severe, or where the harm may only be evident in the future.

B. The veteran is free to involve family members in the disclosure process.

C. If the veteran is deceased, incapacitated, or otherwise unable to take part in a process of adverse event disclosure, the process needs to involve the veteran's personal representative and anyone who is designated by the personal representative.

D. Disclosure of adverse events to veterans or their personal representatives is consistent with VHA core values of trust, respect, excellence, commitment, and compassion. Providers have an ethical obligation to be honest with veterans. Honestly discussing the difficult truth that an adverse event has occurred demonstrates respect for the veteran, professionalism, and a commitment to improving care.

E. Clinicians and organizational leaders will work together to ensure that appropriate disclosure to veterans or their personal representatives is a routine part of the response to a harmful or potentially harmful adverse event. Telling veterans or their personal representatives about adverse events, or potentially harmful adverse events, is never easy, however, it needs to be done and with skill and tact.

F. Disclosure of adverse events and the reporting of adverse events to regulatory agencies are separate requirements. Actions taken to disclose adverse events to veterans according to VHA Handbook 1004.08 in no way obviates the need to report adverse events (and close calls) as required under VHA Handbook 1050.01. Internal reporting through the adverse event and close call reports are protected from disclosure under Title 38 United States Code (U.S.C.) Section 5705. Records protected under 38 U.S.C. Section 5705, that is, quality management/performance improvement and safety activities records, may not be subsequently used as the source of information communicated in the disclosure of an adverse event. VHA Handbook 1004.08 and this Medical Center policy are consistent with The Joint Commission requirement that patients and, when appropriate, their families be told of "unanticipated outcomes" of care (Standard - Ethics, Rights, and Responsibilities (RI) 2.90, CAMH).

G. Despite the general obligation to disclose adverse events to veterans, there are legal restrictions on the information that can be shared. The information communicated to the veteran comes from those involved in the adverse event and from factual information in the veteran's medical record.

H. Confidentiality statutes and regulations, such as the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule,

limit disclosure of any record containing a veteran's personal information to others without the veteran's authorization or other legal authority.

I. In the event of a deceased veteran with no next of kin or legal representative, the clinical disclosure template may be used to document the consideration of a disclosure.

J. The veteran's personal representative is authorized to have access to the protected health information except:

1. Under 38 U.S.C. Section 7332, VHA may not disclose information related to the veteran's treatment for substance abuse (including alcohol), sickle cell anemia disease, or infection with the Human Immunodeficiency Virus (HIV) to others, even after a veteran's death without a "special authorization" or other exception. Questions about release of such information in the case of an adverse event are to be referred to the facility's and/or the VHA's Privacy Officer.

2. Under 38 U.S.C. Section 5705, VHA may not communicate to veterans, or their personal representatives, information that is obtained from documentation of certain quality management activities, such as root cause analyses or patient safety registry records. Rather, the information communicated must come from those involved in the adverse event and from factual information in the veteran's medical record. NOTE: Specific questions regarding sources of information that may not be disclosed or released to the veteran or representative may be found in VHA Handbook 1605.1. Other guidance is available from VHA's Privacy Officer.

14. QUALITY MANAGEMENT PROGRAMS

A. Medical Staff are required to participate in quality management activities; formal and informal involvement is essential to improve patient care and achieve desired patient outcomes.

B. Medical staff need to report issues affecting the quality and safety of health care provided to Veterans. Patient safety incidents or concerns need to be reported to the Patient Safety Coordinator (Manager) or Risk Manager.

15. RESTRAINTS *Restraint During Medical-Surgical Care: (refer to current version of HSPM 11-82-XX for full direction)

Restraints will be initiated through an individual order that must be renewed every calendar day by a qualified house staff (LIP-PGY2 or greater), based on his or her examination of the patient.

If the physician is not available to write the individual restraint or protocol order restraint use can be initiated by a registered nurse based on appropriate assessment of the patient. Qualified house staff (physician) is notified within 12 hours of the initiation of restraint.

If the initiation of restraints is based on a change in the patient's condition, the registered nurse must notify the provider immediately (within one hour of initiation).

Individual Medical Orders: Must be renewed every twenty- four hours. The order will include the time and date and will be written on a specific restraint order form or CPRS template.

Restraint for non-Behavioral Health orders: If the RN initiates use of restraints for non –behavioral health purposes, the LIP provides a verbal or written order within 12 hours of initiation. An LIP must examine the patient face –to- face within 24 hours of initiation of restraints for non-behavioral health purposes.

Restraint for Behavioral Health Reasons: (refer to current version of HSPM 11-85-XX for full direction)

Behavioral restraints are most commonly used on Acute Psychiatry (4AB) but

may be initiated in other areas of the Miami VAHCS such as the Emergency

Department for patients who meet the behavioral restraint criteria.

The written (CPRS) physician order for restraints will include: the time and date; patient behaviors warranting use of Behavioral Health Restraint clinical justification; a specified time limit (no more than 4 hours); the type of Restraint device to be used; and authorization for the registered nurse to release a patient prior to the expiration of the medical order whenever his/her assessment indicates that the patient has met the identified safe level of behavioral control.

All orders are time limited to four (**4**) hours. The original time of the order starts at the time the patient is placed in restraints, not at the time the physician writes the order.

Any renewal of orders for Behavioral Restraint requires a face-to-face reassessment of the patient by the physician every eight (**8**) hours. The new order must be time-limited not to exceed four (**4**) hours.

A registered nurse deemed competent in the use of restraints can institute emergency physical restraint or seclusion use in response to a patient who poses an immediate danger to him or herself or to others. The nurse performs and documents the face-to-face assessment in the progress notes when the procedure is carried out. Emergency implementation may never exceed one hour. A licensed physician (attending physician or PGY 2 or greater) must assess the patients within 1-hour and determine if restraints are to be continued. Qualified resident (physician) must assess the patient within 24 hours of initiation, verify and sign the orders

16. CONFLICT OF INTEREST

A Government employee who is employed by a contractor is prohibited from participating personally and substantially on behalf of the Government through decision, approval, disapproval, recommendation, rendering of advice, certifying for payment or otherwise in that contract. No VA employee who is an employee, officer, director, or trustee of an affiliated university, or who has a financial interest in the contract, may lawfully participate in a VA contract or any other Government contract with the university. VHA is committed to adhering to and enforcing all applicable laws and regulations concerning employee conflicts of interest.

Authority: *Title 18 U.S.C. Section 208(a), and Title 5 Code of Federal Regulations (CFR) Section 2635.402.*

17. INTEGRATED ETHICS

A. The integrated program for ethics in health care that is aligned with the VHA National Integrated Ethics model. The program targets three levels of quality – decisions and actions, systems, and processes. These three levels encompass the full range of ethical concerns that commonly arise in VA as captured in the following content domains.

1. Shared decision-making with patients
2. Ethical practices in end-of-life care
3. Patient privacy and confidentiality
4. Professionalism in patient care
5. Ethical practices in resource allocation
6. Ethical practices in business and management
7. Ethical practices in government service
8. Ethical practices in research
9. Ethical practices in the everyday workplace

B. The MVAHS Integrated Ethics (IE) program is operationalized through three core functions:

1. ethical leadership

2. ethics consultation

3. preventive ethics

18. SUICIDE ASSESSMENT (refer to current version of HSPM 116-06-xx for full direction)

Patients who score positive on the clinical reminders for depression and PTSD should be screened for suicidal ideation, intention and plans utilizing the follow-up clinical reminders in CPRS for positive depression and PTSD screens. Providers will also be asked to screen for suicidal ideation, intentions and plans as part of some consult referrals to Mental Health. Providers should use their own judgment in evaluating their patients for suicidal ideation, intentions and plans when they are not required to by clinical reminders or consult requests. If a provider evaluates a patient as being at high risk for suicide, the provider will be responsible for contacting the appropriate psychiatry provider to conduct a more thorough suicide risk assessment evaluation.

19. ORGAN/TISSUE/EYE DONATION (refer to current version of HSPM 11-05-XX for full direction)

The designated organ, tissue, and eye donation requestor are is Life Alliance. Physicians are responsible for identifying patients who are at risk for impending death are admitted to the Intensive Care Units and who may meet the criteria for organ donation. Physicians will notify the decedent affairs clerk or the administrator on duty who will contact the Designated Requestor to discuss potential donation. Physicians may be asked to initiate the discussion regarding organ donation with family members.

20. BLOOD TRANSFUSIONS (refer to current version of HSPM 113-01-XX for full direction)

Informed consent (written consent) for administration of blood and blood products will be obtained from the patient by the physician. The signed consent is valid for a period of 60 calendar days.

A cross-match is valid for 72 hours. Specimen tubes must be labeled prior to drawing the blood by the person drawing the blood. The labeling will include the patient's first name, last name, social security number, date, and the time drawn, including the readable signature in ink of the authorized person performing the venipuncture.

The physician, oral surgeon or podiatrist ordering the transfusion has the ultimate responsibility for the transfusion process, including recognition and treatment of any complications incurred during or after the transfusion. The ordering

physician, oral surgeon or podiatrist will enter the order electronically in CPRS (VBECS Blood Bank) for all "Blood or Blood Component Transfusion." The patient or authorized designee will sign his/her name on the informed iMedConsent™ for Transfusion of Blood and/or Blood Products.

Printed Hard Copy or paper VA form 10-431a, for Clinical Treatment or procedure and VA Form 10-431b, Consent for Transfusion of Blood Products are 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 iMedConsent ™ software program, or
3. The patient is giving consent by telephone or fax, or
4. The use of the equipment that supports the iMedConsent™ software program would introduce infection control issues such as the inability to adequately disinfect the signature pad used for a patient who is in isolation precautions.

A print out of the electronic CPRS order must accompany the specimen sent to the Blood Bank for testing. The pick-up slip (Form 3230-1) must be sent when requisitioning blood products from the Blood Bank.

Only one unit of blood per patient will be released by the Blood Bank at one time with the exception of blood released to the operating room and blood released to the ward in the case of severely hemorrhaging patients.

21. ANESTHESIA CARE (refer to current version of HSPM 139-03-XX for full direction)

The standards for sedation and anesthesia care apply when patients receive, in any setting, for any purpose, by any route, moderate or deep sedation as well as general, spinal, or other major regional anesthesia.

All procedures requiring sedation and anesthesia care will be performed by staff members who have appropriate training, credentials and privileges, or by house staff under the supervision of attending staff with appropriate credentials. Only individuals with specific privileges through the anesthesia service will be permitted to give deep sedation/analgesia.

All qualified individuals providing sedation and anesthesia care will have appropriate training in professional standards and techniques. The Attending Provider for each procedure will have current Advanced Cardiac Life Support (ACLS) certification and will have completed a VA moderate sedation class within

the past 2 years. Sedation and anesthesia care training will include: (1) administering pharmacologic agents to predictably achieve desired levels of sedation; (2) airway assessment and management; and (3) Monitoring of patients in order to maintain the desired level of sedation.

All qualified individuals administering, monitoring and /or supervising Moderate Sedation will have appropriate training in professional standards and techniques. This will include completion of TMS-based Moderate Sedation Training (TMS Item # 32979) and ACLS in addition to BLS training. Training and testing must be completed prior to the provision of any moderate sedation. An individual must demonstrate sufficient knowledge to administer, monitor, or supervise moderate sedation by obtaining a passing score on VA's TMS Moderate Sedation test. The passing score (established by TMS) must have been obtained no more than 90 days before the privileging/re-privileging action or scope of practice action. TMS-based Moderate Sedation Training is available with the test for those desiring a refresher course prior to testing. For exceptions, please refer to HSPM 139-03-XX.

Individuals providing moderate or deep sedation will have competency-based education, training, experience and will be appropriately credentialed in: (1) Evaluating patients prior to performing moderate or deep sedation or anesthesia; and (2) Methods and techniques required to rescue patients who unavoidably unintentionally slip into a deeper-than-desired level of sedation or analgesia, i.e., management of a compromised airway, inadequate oxygenation and ventilation or compromised cardiovascular system.

Specific locations designated for the provision of sedation and anesthesia care at the Miami VA Healthcare System include the following and are limited to:

Operating Room/Post Anesthesia Recovery (PAR) area - Minimal sedation (anxiolysis), Moderate sedation/analgesia, Deep sedation/analgesia and Anesthesia may be given.

The following locations may only give minimal sedation (anxiolysis) or moderate sedation (conscious sedation): Bronchoscopy area; Cardiac Catheterization Laboratory; Critical Care Units (MICU, CCU, SICU); Dental Clinic; Emergency Room; GI station; and Radiology-CT Scan / MRI / Special Procedures and the Broward Clinic GI suite; Pain Procedure Room in the Pain Center unless the sedation and anesthesia care is being provided by an individual with specific privileges through the anesthesia service.

Anesthesia services can be provided within approximately 30 minutes for patients requiring emergency operative service where anesthesia is deemed necessary.

22. AIRWAY MANAGEMENT OUTSIDE THE OPERATING ROOM (Refer to

current version of HSPM 139-04-XX for full direction)

For Non-anesthesia providers appropriate airway management training will consist of, but not be limited to:

Individuals who are privileged or have a scope of practice to perform Airway Management Outside the Operating Room must successfully complete TMS module on Out-of-Operating Room Airway Management Training (VA16087), the Didactic exam (VA19361), and demonstrate proficiency in the operating room with at least five patients, under the guidance of an Anesthesiology LIP.

23. UNIVERSAL PROTOCOL (Refer to current version of HSPM 112-02-XX for full direction)

The Universal Protocol applies to all surgical and nonsurgical invasive procedures, including procedures done in settings other than the operating room such as a special procedures unit, endoscopy unit, interventional radiology suite or the bedside (i.e. lumbar puncture) or clinic settings (i.e. joint aspirations or joint injections). The following are the required steps:

- Pre–procedure verification
- An ongoing process of information gathering and verification, beginning with

the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the "time out" just before the start of the procedure. This encompasses the informed consent process as well.

- The purpose of the pre-procedure verification process is to make sure that all relevant documents and related information or equipment are:
  - ✓ Available prior to the start of the procedure
  - ✓ Correctly identified, labeled, and matched to the patient identifiers.
  - ✓ Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site.
- Marking the Operative / Procedure site
  - ✓ Acceptable marks are: "Yes" with provider's initials or "Correct Site" with provider's initials.
  - ✓ Non-operative sites should **never** be marked.
  - ✓ The intended site must be marked such that the mark will be visible after the patient has been prepped and draped for spinal procedures, in addition to preoperative skin marking of the general spinal region, special intra-operative imaging techniques may be used for locating and marking the exact vertebral level.
  - ✓ The procedure site must be marked before the procedure is performed and, if possible, with the patient involved.

- ✓ The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstance, the licensed independent practitioner may delegate site marking to:
  1. An individual in a residency program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and **who will be present when the procedure is performed.**
  2. A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse (A.P.R.N.) or physician assistant (P.A.)); who is familiar with the patient; **and who will be present when the procedure is performed.**

- "Time out"
  - The purpose of the time-out is to conduct a final assessment so that the correct patient, site, and procedure are identified.
  - During a time out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.
  - The "time-out" or immediate pre-procedure pause:
    1. Must occur immediately before starting the invasive procedure or making the incision.
    2. Is initiated by a designated member of the team.
    3. Involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operation room technician, and other active participants who will be participating in the procedure from the beginning.
    4. Must be conducted in a "fail-safe" mode, i.e., the procedure is not started until any questions or concerns are resolved.
    5. Even when there is only one person doing the procedure, a brief pause to confirm the correct patient, procedure, and site is appropriate. It is not necessary to engage others in this verification process if they would not otherwise be involved in the procedure.
    6. Must be performed before each procedure is initiated when two or more procedures are being performed on the same patient, procedure, and site is appropriate. It is not necessary to engage others in this verification process if they would not otherwise be involved in the procedure.
    7. Must be performed before each procedure is initiated when two or more procedures are being performed on the same patient, and the person performing the procedure changes.
    8. Must be documented.

- During the time-out, the team members agree, at a minimum, on the following:
  1. Correct patient identity
  2. The correct site
  3. The procedure to be done

23. MEDICATION RECONCILIATION (Refer to HSPM 119-34-XX for full direction)

Medication Reconciliation is the process of comparing the medications that the patient has been taking prior to the time of admission or entry to a new setting with the medications that the patient is about to receive. The purpose of the reconciliation is to avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions, etc.

- Medications must be accurately and completely reconciled across the continuum of care.
- MVAHS must maintain an up to date list of the patient's medications at all times, and must manage this list with the participation of the patient (when possible)
- When a patient changes setting, (ie, admission, transfer, discharge, procedures, ER visit etc) if medications are to be used, or the patient's response to the treatment or service could be affected by medications that the patient has been taking, medication reconciliation must occur.
- The complete list of medications must be provided to the patient on discharge from the facility.
- The complete list of medications must be communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

24. HAND-OFF COMMUNICATION (Refer to HSPM 00-112-XX for full direction)

Hand-off Communication is an interactive process of passing current, need-to-know, patient-specific information from one care provider to another for ensuring continuity of the patient's care.

Hand-offs, can include, but are not limited to nursing shift changes, physicians transferring complete responsibility for a patient, physicians transferring on-call responsibility, assuming temporary responsibility for patient care for a short period of time (i.e., lunch break), anesthesiologist report to post-anesthesia recovery room nurse, nursing and physician hand off from the Emergency Department to inpatient units, , intra- and inter – facility transfers, nursing homes and home health care, critical laboratory and radiology results sent to physician offices, etc.

- The receiver of the information assuming the care of the patient **must** have an opportunity to ask questions to and receive responses from the giver of the information.
- Hand-off communication must, at a minimum, include the following information as appropriate:
- Patient identifiers diagnosis, (DNR) /Code status, Isolation requirements, Fall risk, Elopement/wandering risk, Mentation, Presence of Guardian of Person (Plenary Guardian), Recent changes in patient's condition, Anticipated changes in patient's condition.

25. CRITICAL TESTS AND CRITICAL VALUES (Refer to MPCM 11-03-XX for full direction)

Critical Tests are defined as those Tests ordered as STAT. Critical Values are panic values requiring some type of timely intervention. Critical Values are defined by the respective service, i.e. Lab, Imaging, Nuclear Medicine, Cardiology, etc.

MVAHS has defined the acceptable length of time between the ordering of critical tests and the availability of results and values, as well as the acceptable length of time between the availability of critical results/values and receipt by the responsible licensed care giver. The actual time frames are monitored for compliance with the facility defined expectations, and performance improvement efforts are initiated when performance falls below the expected standard. Refer to full policy for further details.

When critical results are communicated to a provider, they must provide **"read back"** to the individual providing the critical results. This entails **writing down** the information, **reading it back,** and **obtaining confirmation** from the individual issuing the information.

Adopted by the Medical Staff, Miami VA Healthcare System, Miami, Florida, this 31st day December of 2015.

RECOMMENDED

Vincent A. DeGennaro, M.D. — Date: 1/10/16

Chief of Staff

Miami VA Healthcare System

APPROVED

Paul M. Russo, MHSA, FACHE, RD — Date: 1/27/16

Director

Miami VA Healthcare System