Bylaws, Rules and Regulations of the Medical Staff
Of Veterans Health Administration (VHA) Medical Center
Marion, Illinois

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for aspects of that care, the Medical Staff practicing in the VA Health Care System of Marion, Illinois, hereby organized themselves for self governance in conformity with the general policies of the Department of Veterans Affairs (Veterans Health Administration) and the Bylaws, Rules and Regulations hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing VA (Department of Veterans Affairs), and they do not create any rights or liabilities not otherwise provided for in laws or VA Regulations.

FACILITY MISSION STATEMENT

The Marion VA Health Care System is a site in Veterans Integrated Service Network 15 (VISN-15) with the mission to improve the health of the served veteran population by providing primary care, specialty care, extended care, related support services through an integrated health care delivery system; quality health professional education and training based on evidenced based practice and health care support during times of armed conflict to the Department of Defense (DoD) and during national emergencies to the Federal Emergency Management Agency (FEMA).

The Marion Illinois VA Medical Center based in Southern Illinois comprises a medical center, Community Living Center (CLC), Primary Care and Behavioral Medicine Annex in Marion. Marion is the parent facility for a satellite outpatient multi-specialty clinic, Vet center, and Behavioral Medicine annex in Evansville Indiana and community based outpatient clinics located within the patient service area to include the states of Illinois, Western Kentucky, and Southern Indiana. Patients requiring more extensive inpatient, tertiary, or specialty care, services not available or with timely access, are referred to a VISN 15 site, another tertiary care

VA, local community or DOD sites through sharing agreements or fee arrangements with the required services.

DEFINITIONS

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

1. Medical Staff

The Medical Staff consists of fully licensed physicians, dentists, podiatrists, optometrists, and clinical psychologists who hold a current unrestricted license to practice their professions, permitted by law and the facility to provide patient care services independently within the Medical Center and its outlying multispecialty outpatient and community based outpatient clinics. The Medical Staff is organized under a single active category of staff appointed as full or part time, consultant and attending, fee basis or contract, and may be compensated or non-compensated as allowed by VA regulations. The Medical Staff is organized under a single category of membership known as the active Medical Staff.

2. 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 Marion Illinois VA Medical Center Director. The Director is thus 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.

3. Medical Center Director

The Director ("Chief Executive Officer") is appointed by the Governing Body to act as its agent in the overall management of the Medical Center. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS), and the Joint Leadership Council (JLC).

4. Chief of Staff

The Chief of Staff (COS) is the President of the medical staff and Chairperson of the Clinical Executive Board (CEB) also known as the Medical Executive Committee (MEC) and acts as full assistant to the Director in the efficient management of clinical and medical services to eligible patients. The COS also

assists with active maintenance of a medical credentialing and privileging and/or scope of practice system for LIP, Mid-level (Physician Assistants, Advanced Registered Nurse Practitioner, Certified Registered Nurse Anesthetists) and Allied Health Providers (AHP). (Allied Health Providers include, but are not limited to pharmacists (PharmDs), Physical Therapists and Audiologists. Mid-level and Allied Health Providers function under a defined Scope of Practice. The Chief of Staff ensures the ongoing medical education of medical staff.

5. Licensed Independent Practitioner

The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the organization 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, dentists, psychologists, podiatrists, and optometrists.

6. Mid-Level

Mid-level practitioners are those medical providers other than physicians and dentists that function with a Scope of Practice. Mid-level Providers include: physician assistants (PA), and advanced practice nurses (ARNP, CRNA, and CRNP). Mid-level providers do not have clinical privileges, but function with an approved Scope of Practice. They may function with approved "prescriptive authority" under the supervision of a credentialed and privileged licensed independent practitioner. Mid-level providers may have admitting privileges and are authorized to initiate prescriptions for non-formulary drugs when practicing within an approved scope of practice under the direction of assigned supervising physician(s) and according to established processes outlined in Medical Center Memorandum #179.. Prescriptive authority for controlled substances in schedule III, IV, and V may be approved under individual scope of practice if Federal and State Law criteria are met as outlined in VHA Directive #2004-029. Basic criteria include but may not be limited to valid and current DEA number, and for Physician Assistant's, licensure in a state which allows prescriptive authority for controlled substances, with the supervising physician licensed in the same state. Requests will be managed and tracked on an individual basis as presented to Professional Standards Board by the applicable Service Chief.

7. Appointment

As used in this document, the term refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, and/or patient care services at the

medical center. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.

8. Rules

Refers to the specific rules set forth in this document that govern the Medical Staff of the Marion Illinois VAMC. It does not refer to formally promulgated VA Regulations.

9. Clinical Executive Board

The Clinical Executive Board, chaired by the Chief of Staff, is considered to be the Executive Committee of the Medical Staff. The CEB composition and function is described in Article VIII.

10. Professional Standards Board

The Professional Standards Board, a subcommittee of the CEB is established to act on credentialing and clinical privileging matters of Medical Staff. This board also acts on matters involving Allied Health and Midlevel Providers (including PAs, advanced practice nurses, and clinical pharmacists) such as granting prescriptive authority, scope of practice and appointment. Other professional standards boards (e.g. Nursing, etc) will be responsible for advancement and other issues related to their respective professions.

11. VA Regulations

The term VA Regulations means the regulations set by the VHA Central Office and made applicable to its health care facilities in compliance with Federal laws.

12. Emergency

The term emergency is defined as a condition in which serious permanent harm would result to the patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to such permanent harm or life-threatening danger.

13. Moderate Sedation or Analgesia

Moderate Sedation or Analgesia ("conscious sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, no interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. (VHA Directive 2006-023)

14. Telemedicine

The term "telemedicine" shall refer to the use of electronic communications and information technology to provide and support health care and education when distance separates the participants.

15. Electronic Medical Record (EMR)

For the purposes of this document, VISTA/CPRS will be referred to as electronic medical record (EMR)

16. DEAN'S COMMITTEE:

Committee established by a formal memorandum of affiliation between the facility and medical and dental school and approved by the Chief Medical Director; composed of deans, senior faculty members of the affiliated medical school, and staff of the VA Medical Center, Marion, Illinois as appropriate to consider and advise on development, management and evaluation of all educational and research programs conducted at the facility. The Deans Committee also serves in the capacity of the Medical Subcommittee for the Academic Affiliation Council.

17. SPECIFIED PROFESSIONAL PERSONNEL

Individuals who are licensed practitioners but do not meet the requirements for medical staff membership: members of the house staff, speech pathologists, audiologists, nurse clinicians, nurse practitioners, social workers, alcohol/drug counselors, physician assistants and other personnel qualified to render direct medical care under the supervision of a medical staff member who has clinical privileges in the facility.

18. CLINICAL PRIVILEGES

Permission granted to medical staff members to render specific patient services.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of the Veterans Affairs Medical Center, Marion, Illinois. Members practice in one or more of its facilities.

ARTICLE II: PURPOSES

The purpose of the Medical Staff shall be to:

1. Oversee the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

2. Ensure that all patients treated at any site of the VA Health Care System, Marion, Illinois, or on any of the services, will receive efficient, timely, appropriate care that is subjected to continuous quality improvement practices.

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

4. Establish, and assure adherence to, an ethical standard of professional practice and conduct.

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

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

7. Ensure 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.

8. Participate in the measurement, assessment, and improvement in health care processes.

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

10. Bring the dimension of Medical Staff leadership to deliberations by the Medical Center Director and the Governing Body.

11. 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.

12. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.

13..Establish medical center policy for patient care and treatment and to implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.

14. 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.

15. To initiate and maintain an active Continuous Quality Improvement Program in all aspects of medical practice. Daily operations will be the subject of Continuous Quality Improvement, as defined through Medical Center publications.

16. To coordinate and supervise the scope of practice of all mid-level and appropriate allied health provider staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each mid-level and appropriate allied health provider 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: MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff is a privilege that shall be extended only to, and continued for, professionally competent physicians, dentists, podiatrists, psychologists, and optometrists who continuously meet all the qualifications, standards and requirements of VHA, this facility, and these Bylaws. Membership may be considered for other licensed individuals who are permitted by law, to provide patient care services independently and who meet the qualifications, standards and requirements of VHA, this facility, and these Bylaws.

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, or membership or non-membership in a labor organization, or on the basis of any other criteria unrelated to professional qualifications.

a. Categories of Medical Staff Membership

The Medical Staff shall be divided into active and consulting staff. Categories of Medical Staff membership include:

(1) Active Medical Staff: defines staff members who are employed by the Department of Veterans Affairs or any who hold official administrative appointments. Attendance at medical staff meetings is required for this category unless formally excused or unless employed on half-time or less basis. Practitioners who provide services on contract will be considered Active members only if they provide services for 20 or more hours per week.

(2) Consultant Staff *(Consultants, intermittent, WOC, on-station fee basis, on-station contract, telemedicine, or on-station sharing agreement)*: are not otherwise members of the medical staff and meet the general qualifications for credentialing. They must possess adequate clinical and professional expertise; be willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence; have satisfactorily completed credentialing requirements; and are employed by an appropriate Department of Veterans Affairs mechanism. These members are encouraged to attend meetings of the medical staff; however, attendance is not mandatory because of the nature of their clinical activities at this medical center. They may attend meetings of the service of which he/she is a member including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

**** Consultants, intermittent, WOC and contract physicians are not eligible to hold office in the Medical Staff organization.***

(3) Other Licensed Professionals: means those individuals permitted by law, the Department of Veterans Affairs and this facility to provide patient care services independently without supervision, direction or consultation. These individuals are encouraged to attend medical staff meetings, but attendance is not mandatory.

(4) Graduate Educational Programs (Residents): means those individuals who are qualified to render direct medical care under the supervision of a licensed staff physician who has clinical privileges in the areas they are supervising. A *Resident Credentialing Verification Letter (RCVL)*, signed by the Program Director and the Medical Center Director and updated annually, will be on file in the Director's office as required by VHA policy. Residents are not permitted to vote or hold office in the Medical Staff organization. They may attend meetings but are not required to attend.

(5) Specified Professional Personnel: means those individuals who are licensed practitioners, but do not provide patient care services independently and do not meet the requirements for Medical Staff membership. At this medical center this means physician assistants, nurse practitioners, and nurse anesthetists. These individuals are encouraged to attend medical staff meetings, but attendance is not mandatory.

3.2 QUALIFICATIONS FOR MEMBERSHIP AND CLINICAL PRIVILEGES

To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.1 must submit evidence of:

a. Active, current, full, and unrestricted license to practice his/her 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.

b. Education applicable to individual Medical Staff members as defined, e.g., hold a degree of Doctor of Medicine, Osteopathy, Dentistry, Optometry, and/or Podiatry from an approved college or university.

c. Relevant training and/or experience consistent with professional assignment and privileges for which applying including internships, residencies, board certification or specialty training.

d. Current competence consistent with professional assignment and privileges for which applying.

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

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

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

h. English language proficiency and photo identification.

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

j. For on call responsibility, ability to meet response time criteria as defined by the individual services.

k. Ability to meet application criteria established for appointment to VA Service.

l. Photocopy of a current government identification (i.e. driver's license signed with a current date or other appropriate picture identification as deemed necessary).

m. Provide care to patients within the scope of privileges and advise the Director, through the Chief of Staff, of any change in ability to meet fully the criteria for Medical and Dental Staff membership or to carry out clinical privileges which are held.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

a. The management and coordination of each patients care, treatment and services is the responsibility of a practitioner with appropriate privileges and they will provide for continuous care of patients assigned to their care.

b. Observe Patients' Rights in all patient care activities to involve patients in all aspects of their care including pain management.

c. Participate in a leadership role in organizational performance and process improvement activities to include continuing education, peer review, medical staff monitoring and evaluation, patient safety, and medical center committee membership In order to improve quality of care, treatment, and services.

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

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

(2) Provide care to patients within the scope of privileges and advise the Medical Center Director through the Chief of Staff of any change in ability to meet fully the criteria for Medical Staff membership or to carry out clinical privileges which are held.

(3) Advise the Medical Center Director of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of notification of such occurrences and their outcome consistent with requirements for appointment under Article IV of these Bylaws.

e. Abide by the Medical Staff Bylaws, Rules and Regulations and all other lawful standards, policies and rules of the Marion, Illinois VA Medical Center and Veterans Health Administration. This agreement shall be documented by signature on Attachment D of these Bylaws and/or the Supplemental Information form to the Application for Physicians, Dentists, Podiatrists, and Optometrists (VAF 10-2850).

3.4 CONDITIONS AND DURATION OF APPOINTMENT

a. <u>Procedure of Appointment</u> - VA Manual MP-5, part II, chapter 2 and its supplements provide procedures for appointment of physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and medical support personnel. MP-5, Part II, references the authority of 38 U.S.C., Ch. 73.

b. <u>Terms of Appointment</u> - In accordance with 38 U.S.C. all permanent appointments of physicians and dentists and other health care professionals are subject to a two-year probationary period. VA Manual MP-5, part II, chapter 2, and its supplements provide VA policy and procedures.

ARTICLE IV
APPOINTMENT AND INITIAL CREDENTIALING

4.1 GENERAL PROVISIONS

a. All members of the Medical Staff as defined in Article III, Section 3.1(b) and all non-Medical Staff practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment, appraisal, reappraisal, break in service, or revision for granting of clinical privileges or scope of practice. Credentials that are subject to change during leaves of absence will be subjected to review at the time the individual returns to duty.

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

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

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

(3) Fee appointment in accordance with 38 U.S.C. 7405(a)(2)

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

d. All medical staff, allied health and midlevel providers must submit credentialing information into VetPro as required by VA guidelines.

e. Deployment/Activation Status:

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 provider from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of l994 (USERRA), the provider will update the credentialing file to current status.

After verification of the updated information is documented by the Credentialing Office, the information will be referred to the practitioner's service chief then forwarded to the Chief of Staff for recommendation to restore privileges to active, current status. The Director has final approval for restoring privileges to active and current status.

In those instances where the privileges lapsed during the call to active duty, the provider needs to provide additional references for verification and all verifications required for reappointment need to be done.

In those instances where the provider was not providing clinical care while on active duty, the provider 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 needs to be initiated, on a short-term basis.

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 Marion VAMC Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed.

4.2 APPLICATION PROCEDURES FOR APPOINTMENT

Applicants for appointment to the Medical Staff must submit a completed application and enter electronic credentialing data through VetPro. To be complete, applications for appointment must be submitted by the applicant on forms approved by VA and/or the facility and include authorization for release of information pertinent to the applicant and information regarding:

(a) Items specified in Article III, :

**** Active, Current full and unrestricted license*** **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 revocation for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily 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).**

**** Education***
**** Relevant training and/or experience***
**** Current professional competence and conduct***
****Basic Life Support current card per approved program using criteria by the American Heart Association or designated approved DOD agency.***
**** Physical and mental health status***
**** Response time from residence (for on-call responsibility)***
**** Professional liability insurance (contractors)***
**** English language proficiency***
**** Board Certification/Board Elgibility (unless otherwise exempt) (10-97-031 Under Secretary for Health Information Letter Board Certification for Physicians)***
****To qualify for moderate sedation and airway management privileges, the practitioner will meet the special qualifications outlined in the privileges delineation form and be accountable to providing verifiable documentation of completion of requirements of competency.***

(b) U.S. Citizenship. Applicants must be a citizen of the United States. When it is not possible to recruit qualified citizens, practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for temporary appointment, with sight verified proof of current VISA status and

documentation from Immigration and Naturalization Service of employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.

(c) References. Names and addresses of a minimum of three (3) individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested. At least one of the references must 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 Facility 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;

**** Name of health care institution or practice,***
**** Term of appointment or employment, and reason for departure***
**** Privileges held and any disciplinary actions taken against the privileges, including suspension, revocation, limitations, or voluntary surrender.***

(e) DEA (Drug Enforcement Administration) Registration. Of those who have, or have had, DEA registration (current or inactive)

(1) previously successful or currently pending challenges to DEA registration or the voluntary or involuntary relinquishment of such registration.

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

(g) Status of any Claims - 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) Pending challenges against the practitioner by any hospital, licensing board, law enforcement agency, professional group or society.

(j) Authorization for Release of Information including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.

DOCUMENTS REQUIRED IN ADDITION TO THOSE LISTED ABOVE: (Note: Verification is defined as primary source documentation by letter, telephone call, computer print out or internet verification) See VHA Credentialing and Privileging Handbook 1100.19 and VA Handbook 5005, Part II, Chapter 3.)

(a) Pre-employment References: A minimum of three references from individuals able to provide authoritative information regarding the individual's training/experience, professional competence, conduct and health status. At least one of the references must be from the current or most recent employer(s) or institution(s) where clinical privileges are/were held. In the case of individuals completing residencies, one reference must come from the residency program director.

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

(c) Verification of status of licenses for all states in which the applicant has ever held a license.

(d) For Foreign Medical Graduates, evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate.

(e) Evidence and verification of board certification.

(f) Verification of education credentials used to qualify for appointment (and privileges) including all postgraduate training.

(g) evidence of submission of query to NPDB (National Practitioner Data Bank), and the Healthcare Integrity and Protection Data, for all members of the Medical Staff and those licensed practitioners with clinical privileges.

(h) Confirmation of health status and photo identification for verification.

(i) Evidence and verification of the status of any alleged or confirmed malpractice from legal counsel and/or insurance claim departments.

(j). Bylaws Receipt and Pledge. Prior to the granting of clinical privileges, Medical Staff members or applicants will pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws, Rules and VHA Regulations.

(k) OIG Sanction list query

NOTE: All healthcare providers must submit credentialing information into Vet Pro as required by VA Guidelines.

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 may serve as a basis for denial of employment consideration.

4.3 PROCESS AND TERMS OF APPOINTMENT

a. The Service Chief to which the applicant is to be assigned is responsible for recommending appointment to the Executive Committee of the Medical Staff based on evaluation of the applicant's completed application, credentials and determination that service criteria for clinical privileges are met.

b. Credentialing staff will confirm that if the response to the NPDR-HIPDB 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.

c. The Executive Committee Professional Standards Board of the Medical Staff recommends a medical staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

d. Appointments to the Medical Staff should be acted upon by the Medical Center Director within 30 days of receipt of a complete application package including all required verifications, references and recommendations from the appropriate Service Chief, Professional Standards Board (PSB) and the Dean's Committee, if applicable.

e. 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 application because of inadequate information. The notification to the requesting practitioner will not exceed 2 weeks from the signed date of decision. If the appointment is not approved, reasons will be provided.

f. Temporary Appointment: When there is an emergent or urgent patient care need, a temporary Medical Staff employment appointment, under the provisions of 38 U.S.C. 7405(a) (1), VA Handbook 5005, Part II, Chapter 3 may be approved by the Director, upon recommendation of the Chief of Staff, prior to receipt of references or verification of other information and action by recommending committees. A complete application, verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted submission of a National Practitioner Data Bank/HealthCare Integrity and Protection Data Bank (NPDB/HIPDB), and federal and state Medical Boards query, and an oral or written reference will be obtained prior to making such an appointment. The complete appointment process must be completed within 60- calendar (45-work) days of temporary appointment or appointment will be automatically terminated.

ARTICLE V: CLINICAL PRIVILEGES

5.1 GENERAL PROVISIONS

a. Medical Center specific privileges are granted for a period of no more than two (2) years.

b. Biennial reappraisal of each Medical Staff member who holds clinical privileges is required. Reappraisal includes a review of performance and an evaluation of the individual's physical and mental health status, as well as assessment of the individual's current privileges. The ongoing professional practice evaluation/QM file is used in evaluation. It also requires verification of satisfactory completion of sufficient continuing education as required by the primary state licensing board. Reappraisal is initiated by the practitioner's Service Chief at the time of a request by the practitioner for new and renewed clinical privileges.

c. A practitioner's request for modification/enhancement of existing clinical privileges is made by the practitioner's submission of a formal written request to the appropriate service chief for presentation to the PSB for the desired change(s)

with full documentation to support the change. Licensure is verified with the primary source for inclusion in decision on revision of clinical privileges.

d. Other licensed practitioners who are presently permitted by law and this facility to provide patient care services independently may be granted clinical privileges (psychologists, optometrists, podiatrists). For other specified professional personnel, job description or scope of practice statement (speech pathologists, therapists, etc.) may be granted rather than delineated clinical privileges.

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

f. Practitioners with clinical privileges are assigned to and have clinical privileges in one service, but may be granted clinical privileges in other clinical departments. Clinical privileges granted extend to all physical locations of the designated service(s) within the jurisdiction of the medical center and its service area and according to approved site specific grid.

g. Exercise of clinical privileges within any service is subject to the rules of that service and to the authority of that Service Chief.

h. When certain clinical privileges are contingent upon appointment to the faculty of affiliates, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.

i. Telemedicine - All providers involved in the provision of clinical telehealth are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, "Credentialing and Privileging", and in accordance with Marion policy. Physicians credentialed and privileged as part of the Medical Staff and Allied health and Mid-level providers operating under a Scope of Practice of the Marion VA Medical Center are deemed qualified to provide telehealth to all facilities within the facility and its patient service area (i.e., OPCs and CBOCs).

5.2 PROCESS & REQUIREMENTS FOR REQUESTING CLINICAL PRIVILEGES

a. <u>Burden of Proof</u>. The practitioner requesting clinical privileges must furnish all information needed for a proper evaluation of professional competence, conduct, ethics and other qualifications. The information must be complete, accurate, and verifiable. If questions arise, the requesting provider is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to

provide necessary information within the specified time period may serve as a basis for denying clinical privileges.

b. All practitioner requests for clinical privileges must be made in writing and include privileges requested in a format approved by the Medical Staff.

c. The practitioner applying for initial clinical privileges must submit a complete application for privileges that will include:

(1) Complete appointment information as outlined in the Medical Staff bylaws.

(2) Application for clinical privileges as outlined in this Article.

d. The practitioner applying for clinical privileges subsequent to those granted initially will provide the following information:

(1) An application for clinical privileges as outlined in 5.2(b) of this Article. (Since practice, techniques, and facility missions change over time, it is expected that modifications, additions or deletions to existing clinical privileges will occur). Practitioners are encouraged to consider carefully and discuss appropriateness of specific privileges with the appropriate service chief prior to formal submission of the request.

(2) Supporting documentation of professional training and/or experience not previously submitted.

(3) Physical and mental health status as it relates to practitioner's ability to function within privileges requested including such reasonable evidence of health status that may be required by the Executive Committee of the Medical Staff.

(4) Documentation of continuing medical education related to area and scope of clinical privileges as required by the primary state licensing board.

(5) Status of all licenses, certifications held.

(6) Any sanction(s) by a hospital, state licensing agency or any other professional health care organization; voluntary or involuntary relinquishment of licensure of registration; any malpractice claims, suits or settlements and the status thereof; reduction or loss of privileges at any other hospital within 15 days of the adverse action.

(7) Response time from residence to facility for on-call responsibilities as applicable.

(8) Names of other hospitals at which privileges are held. Copies of the privileges held at other facilities will be requested by the credentialing office.

(9) Names/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.

(10) BLS approved program meeting criteria by the American Heart Association or designated approved DOD agency. To qualify for moderate sedation and airway management privileges, the practitioner will have specific, approved clinical privileges and will acknowledge that they agree to the guidelines outlined in policy.

e. <u>Bylaws receipt and pledge</u>. Prior to the granting of clinical privileges, Medical Staff members or applicants will pledge to provide for continuous care of their patients and will receive a copy of the Bylaws and Rules and agree to abide by the professional obligations therein.

NOTE: *This requirement can be satisfied for those individuals seeking privileges subsequent to those granted initially by having a signed acknowledgment of receipt and agreement on file for the most current Bylaws, Rules and Regulations.*

f. <u>Verification</u>:

(1) Verification of credentials prior to granting of initial privileges will be accomplished as described in Article 4, "Appointment and Initial Credentialing."

(2) Before granting subsequent clinical privileges, the Chief of Staff will assure that the following information is on file and verified with primary sources and according to policy, as applicable:

**** Current and former licenses in all states***
**** Current and former DEA license and/or registration***
**** National Practitioner Data Bank query***
**** Physical and mental health status information from applicant***
**** Physical and mental health confirmation and professional competence information from peers and division director.***
**** Continuing medical education to meet any local requirements for privileges requested***

** Board certification(s)*
** Quality of care information*

5.3 CREDENTIALS EVALUATION AND MAINTENANCE

a. 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 the scope of their delineated clinical privileges.

b. VHA Policy and procedure will be followed as defined in Handbooks & Directives as well as policy of the credentialing office.

c. Effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as two letters of request.

d. A Credentialing and Privileging Folder and/or VetPro Internet file will be established and maintained for each practitioner requesting privileges. These folders /files will be the responsibility of the credentialing office and will contain all documents relevant to credentialing and privileging. At any time that a folder is found to lack required documentation for any reason, effort will be made to obtain documentation. When it is not possible to obtain documentation, an entry will be placed in the Folder stating the reason. The entry will also detail the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort.

5.4 RECOMMENDATION AND APPROVAL

a. Peer recommendations will be obtained from individuals who can provide authoritative information regarding training/experience, professional competence and conduct and health status.

b. The Service Chief to whose service the applicant for clinical privileges is assigned is responsible for assessing all information and recommending approval of clinical privileges. The PSB as representatives of the organized medical staff reviews and analyzes for final vote and forward to the Medical Center Director.

(1) Recommendation for initial privileges will be based on determination that applicant meets criteria for appointment and clinical privileges for the service including requirements regarding education, training, experience, references and health status.

(2) Recommendation for clinical privileges subsequent to those granted initially will be based on, at least, reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment and clinical and/or technical skills and quality of care including results of monitoring and evaluation activities where applicable (such as surgical case review, mortality assessments, drug usage evaluation, infection rates, medical record review, blood usage review, pharmacy and therapeutics review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities)and Focused Professional Practice Evaluations

(3) The Executive Committee of the Medical Staff recommends granting clinical privileges based on each applicant's successfully meeting the requirements for clinical privileges as specified in these Bylaws.

(4) Clinical privileges are acted upon by the Medical Center Director within 30 days of receipt of a fully complete application for clinical privileges that includes all requirements set forth in these bylaws.

(5) Originals of approved clinical privileges documents are placed in the individual practitioner's Credentialing and Privileging Folder.. Copies are distributed to the practitioner, service chief, and OR, ER, ICU, etc. as appropriate, for comparison with practitioner orders and procedures. In addition, a site-specific grid will be made available to all practice sites and to all providers to illustrate the medical center locations that can support a specific procedure with competent staff and necessary equipment and supplies. The electronic posting for access to those persons with a need to know, will be managed and kept current by the facility credentialing office.

(6) The Clinical Executive Board may recommend a change in the clinical privileges or service assignment of a member. The Clinical Executive Board may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to a period of proctoring until a report of observation and evaluation of performance and technique is received, signed through the focused practitioner practice evaluation by the service chief and/or assigned proctor.

(7) If a Medical Staff member requesting renewal and/or modification of clinical privileges fails to timely submit his/her request and furnish the information necessary to evaluate the request, the privileges shall automatically lapse.

5.5 Vet Pro Documentation and Focused Practitioner Practice Evaluation

a) 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.

b) 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.)

c) A Credentialing and Privileging (C&P) folder and complete electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C & P folder will be the Credentialing and Privileging Supervisor/Quality Management Service and will be maintained by that office. At any time that a file is found to lack required documentation for any reason, effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the folder stating the reason. The entry will also detail the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort.

d) 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. The FPPE at time of initial appointment will be for a period not to exceed 90 days; however, may be extended and/or a different type of evaluation process assigned if needed. The Service Chief will appoint an evaluator and will meet with the provider to explain what will be reviewed during this review period and document said discussions on the policy attachments.

B. The FPPE at the time of request for additional privileges will be for a period to be set by the Service Chief, due to the scheduling of services. The Service Chief will appoint an evaluator and will meet with the provider to explain what will be reviewed during this review period and document agreement on policy attachment.

C. The FPPE initiated by a "for-cause" event requiring a focused review will be for a period to be set by the Service Chief. The Service Chief will appoint an evaluator and will meet with the provider to explain what will be reviewed during this review period and document discussion on the FPPE policy attachment.

D. The FPPE monitoring process will clearly define and include the following as found in MCM 11-11C-663:

- **criteria for conducting the FPPE**
- **method for monitoring for specifics of requested privilege**
- **statement of the "triggers" for which a "for-cause" FPPE is required**

- **measures necessary to resolve performance issues which will be consistently implemented**

E. Information resulting from the FPPE process will be integrated into the service specific performance improvement program, consistent with the services' policies and procedures.

F. If at any time the Service Chief or designee cannot determine the competence of the provider being evaluated during the FPPE process the following may occur:

- **Extension of FPPE review period**
- **Modification of FPPE criteria**
- **Privileges (initial or additional) may not be maintained**
- **Termination of existing privileges**

5.6 EXCEPTIONS

a. <u>Expedited Credentialing and Privileging Process</u> - for emergent or urgent patient care needs <u>temporary privileges</u> may be granted at the time of a temporary appointment for a limited period of time (not to exceed 60 calendar days) by the Medical Center Director on the recommendation of the Chief of Staff. Medical Staff approved criteria are utilized in review of request for the expedited process with a grid tracking eligibility or ineligibility accordingly. The applicant for temporary appointment and clinical privileges is considered ineligible for the expedited process if any of the following conditions are known:

- **The application is incomplete**
- **There is a current challenge or previous successful challenge to licensure or registration**
- **Involuntary termination of medical staff membership at another organization**
- **Involuntary limitation, reduction, denied or loss of clinical privileges**
- **An unusual pattern of or an excessive number of professional liability actions resulting in final judgment against the applicant.**

<u>Temporary privileges</u> In addition to the above listed exclusion criteria, verification of the following will be used to base approval:

1) **Current licensure**

2) **Relevant training and experience**

3) **Current competence for privileges requested**

4) **A query and evaluation of NPDB-HIPDB information**

5) FSMB query and evaluation of information received

6) Completed application must be submitted within three days of temporary privileges being granted.

b. Termination of temporary privileges: Temporary privileges shall automatically terminate at the end of the designated period. The Medical Center Director may at any time, upon the recommendation of the Chief of Staff or the Service Chief involved, terminate a practitioner's temporary privileges. The appropriate Service Chief or, in their absence, the Chief of Staff, shall assign a member of the medical staff to assume responsibility for the care of the terminated practitioner's patient(s) until they are discharged from the Medical Center.

c. Disaster Privileges – 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 (Marion Disaster Plan; MCM 063, "Medical Center Emergency Preparedness Plan;" and MCM 195, "Medical Staff Appointments and Clinical Privileges"). The Medical Center Director, Chief of Staff, or their designee may grant disaster privileges to recognized, qualified non-VA providers when the emergency management plan has been activated, and the Health Care System site is unable to handle the immediate patient needs. Unless otherwise designated, the verification and identification process will occur at the Command Post and be managed according to the Disaster Plan. Any one of the following will be accepted as credential verification process for emergency volunteers to provide patient care in the medical center:

1) A current medical facility photo ID card

2) Evidence of a current license (pocket card sufficient) to practice

3) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); or

4) Identification that the individual has been granted authority to render patient care in emergency circumstances, which authority having been granted by a Federal, State, or municipal entity.

The documentation will serve as credentialing verification for the period not to exceed 10-calendar days or length of the disaster, whichever is shorter. Licensure primary source verification will be obtained within 72 hours after the disaster control, or as soon as possible in extraordinary circumstances.

In circumstances where communication methods utilized to verify credentials fail or are unavailable exceeding 10 calendar days or the length of the declared disaster, whichever is shorter, the practitioner needs to be converted to Temporary Privileges not to exceed 60 working days in accordance with VHA Handbook 1100.19, Credentialing and Privileging.

An assigned, appropriately credentialed and privileged physician oversees the professional practice of the volunteer licensed independent practitioner and/or mid-level and certain allied health providers.

d. Emergency care: In any emergency, any member of the medical staff, to the degree permitted by his/her license and regardless of privileges, department, service, or medical staff status or lack of it, shall be permitted and assisted to use every facility of the hospital and to do everything possible to treat the patient. For the purpose of this section, an emergency is defined as a condition in which immediate treatment is necessary to prevent serious permanent harm to a patient, to preserve the life of a patient, or to prevent serious deterioration or aggravation of a patient's condition.

Emergent privileges may be granted by the Medical Center Director at the recommendation of the Chief of Staff to manage an isolated patient case need on site by an outside provider and not in the confines of the emergency management plan.

ARTICLE VI: FAIR HEARING AND APPELLATE REVIEW

6.1 DENIAL OF MEDICAL STAFF APPOINTMENT

When review of credentials and recommendations contained in a complete application result in denial of appointment, the applicant will be notified by the chairperson of the Executive Committee of the Medical Staff in a letter over the signature of the Medical Center Director.

6.2 SELF-GOVERNANCE ACTIONS

a. Rules and Regulations: The Medical Staff shall initiate and adopt such rules and regulations as it may deem necessary for the proper conduct of its work and

shall periodically review and revise its rules and regulations to comply with current medical staff practice. The Medical Staff Bylaws, Rules & Regulations are not unilaterally amended. Recommended changes to the rules and regulations shall be submitted to the Medical Executive Committee for review and evaluation prior to presentation for consideration by the Medical Staff as a whole. Following adoption such rules and regulations shall become effective after approval by the Medical Center Director.

b. Authority to Act: Any member or members who act in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

c. Notices: A Medical Staff member (all categories) shall notify the Chief of Staff or Medical Center Director if his/her license to practice medicine, dentistry, or podiatry or if his/her Drug Enforcement Agency number has been suspended, revoked, restricted, or surrendered. Within five days of occurrence a Medical Staff member (all categories) shall notify the Chief of Staff or the Medical Center Director of any reduction, suspension, termination or limitation imposed on the member's privileges at another health care facility.
Exception: **Unless the action arises out of a failure to complete medical records in a timely manner.**

d. Mandatory Training: ACLS Certification: Any medical staff members who may serve as the lead code team member responsible for performing resuscitations shall have current ACLS (Advanced Cardiac Life Support) certification. Proof of ACLS certification must be presented at the time of credentialing. ***(Medical Center Memorandum No. 47).*** **Out of OR Airway Management: Any provider applying for intubation privileges will comply with education requirements as outlined in MCM 609. Moderate Sedation: Any provider requesting privileges for moderate sedation must complete competency requirements as defined in MCM 402.**

e. MOD Guidelines: The MOD will not leave the facility grounds during their call shift without the permission of the Chief of Staff or designee, at which time another physician will be designated. The MOD will not leave the facility until the designated physician reports for duty. Call schedules for MOD duty will be clearly posted in the triage area, admission office, nursing stations and page operators. The MOD will not be on call for another organization during the scheduled shift for VA. Call schedules will be updated monthly and distributed as above upon receipt.

6.3 ACTIONS AGAINST CLINICAL PRIVILEGES

a. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be substandard care demonstrate professional

incompetence or professional misconduct (VHA Handbook 1100.19), or to be disruptive to the operations of a System facility, a review by the appropriate PSB, or appropriate subcommittee, will be initiated by the Chief of Staff. Any requests for review from facility Service Chiefs will be in writing to the Chief of Staff and will be supported by reference to specific activities or conduct, which constitute the grounds for the request.

b. Specific Circumstances of unacceptable, disruptive behavior (Disciplinary/Grievance Procedures Are Covered in VHA Handbook 5021 Employee/Management Relations) shall include, but are not necessarily limited to, the following:

- **A. Profane or disrespectful language;**
- **B. Demeaning behavior (for example, referring to hospital staff as "stupid");**
- **C. Sexual comments or innuendo;**
- **D. Outbursts of anger or other hostile/threatening interactions;**
- **E. Throwing instruments or other paraphernalia;**
- **F. Criticizing hospital staff in front of patients or other staff;**
- **G. Negative comments about another physician's care;**
- **H. Inappropriate CPRS notes (for example, critical comments about other caregivers;**
- **I. Any other verbal, written, psychological, or physical abuse of another person**

3. Reduction and Revocation of Privileges

A. General Provisions

1) Reduction of privileges may include, but not be limited to, restricting performance of specific procedures, or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area. Revocation of privileges refers to the permanent loss of clinical privileges.

2) If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures indicated in these bylaws must be followed. Procedures for reduction of privileges are described in subparagraph B. Procedures for revocation of privileges apply to all employees included within the scope of these bylaws as specified in subparagraph C.

B. Reduction of Privileges

1) Prior to any action or decision by the Director, the employee will

receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include a discussion of the reason(s) for the change. The notice will also include a statement of the employee's right to be represented by counsel or representative of employee's choice, throughout the proceedings.

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

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

4) The Director will appoint a review panel of three professionals within five workdays after receipt of the employee's request for hearing to conduct a review and hearing. At least two members of the panel will be members of the same profession, i.e., a physician or dentist.

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

6) The panel will complete its review and submit its report within 15 workdays of the date of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.

7) The Director will issue a written decision within l0 workdays of the day of receipt of the panel's report. If the employee's privileges are reduced, the written decision will indicate the reason(s) for the change.

8) The employee may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.

9) The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the employee's appeal. The decision of the VISN Director is not subject to further appeal.

10) An employee who does not request a review panel hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN Director within five workdays after receipt of the Director's decision.

11) The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.

C Revocation of Privileges

1) Proposed action taken to revoke a staff member's privileges will be made using VHA procedures. In instances where revocation of privileges is proposed for permanent employees, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code. For probationary employees appointed under 38 U.S.C. 7401(1), the proposed revocation will be combined with probationary separation procedures contained in VHA Handbook 5021 Employee/Management Relations. For employees appointed under 38 U.S.C. 7405, the proposed revocation will be combined with procedures similar to those for probationary employees, except that the Director will be the approving authority and the decision of the Director will be final.

2) Revocation procedures will be conducted in a timely fashion. If discharge, separation during probation, or termination of appointment is not proposed, revocation of clinical privileges may not occur.

4. Suspension (for Administrative Reasons): Failure on the part of any staff member to complete medical records in accordance with system policy or use a pre-populated template note or copy and paste function will result in progressive disciplinary action to possible indefinite suspension.

5. Reporting to the National Practitioner Data Bank (NPDB) – VHA Handbook 1100.17

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

B. When a claim is settled (and a payment made), a VA peer review is conducted to determine if the involved physicians should be reported to the NPDB. The peer review must determine that there was substandard care, professional incompetence, or professional misconduct for a physician to be reported.

C. Beginning in July 1997, all such reviews are being performed nationally from a single office using outside consultant reviewers. Accordingly, a letter is now sent to physicians involved in the plaintiff's case when a tort claim settlement is about to be submitted for peer review.

D. Physicians 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.

6. Reporting to State Licensing Boards: The System has a responsibility to report to state licensing boards employed 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. VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards, defines the procedures, including an individual's right to due process requirements.

7. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign temporarily 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. 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.

Matters of individual physician health that may affect the ability to safely carry out the clinical privileges as delineated will be addressed according to processes defined by medical staff leadership with the purpose of assistance and rehabilitation Impaired Professional Program: It is the policy of the medical staff and the medical center to be sensitive to a practitioner's health or conditions that may adversely affect the physician's ability to provide safe, competent care to patients. Management of matters of individual physician's health will be accomplished through the Employee Assistance Program with a focus on assistance and rehabilitation. Members of the Professional Standards Board will convene as representatives for review, validation, and recommendation on a case-by-case basis in a confidential session separate in process than disciplinary function. Modification or accommodation to clinical privileges, if considered appropriate, will be discussed with the professional with identified plans to include goals and time frames. Agreement will be documented in minutes of the PSB with recommendations forwarded to the Medical Center Director. If disagreement occurs, the Chief of Staff and Medical Center Director

will meet with the provider for resolution.
(MCM 645, *Medical Staff Declaration of Health*).

The Medical Center Director, may on the recommendation of the Chief of Staff, summarily restrict or suspend privileges, on a temporary basis, pending the outcome of formal action when there is sufficient concern regarding patient safety or specific practice patterns consistent with requirements in VHA policy on credentialing and privileging of physicians and dentists.

6.4 REPORTING ADVERSE ACTIONS

Disclosure of information to the National Practitioner Data Bank through State Licensing Boards regarding adverse action against clinical privileges of more than 30 days will follow provisions of the VHA policy on National Practitioner Data Bank reports.

6.5 REPORTING MALPRACTICE PAYMENTS

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

6.6 TERMINATION OF APPOINTMENT

Termination of Medical Staff appointments will be accomplished in conjunction with, and follow procedures for, terminating appointments of practitioners set forth in MP-5, part II, chapters 4, 8, and 9, and Federal and VA acquisition regulations. Appeal rights are found in MP-5, part II, chapter 8. Disciplinary Actions, Grievances and Hearings (MP-5, part II, chapter 4) references probationary periods.

ARTICLE VII: ORGANIZATION OF THE MEDICAL STAFF

7.1 OFFICERS OF THE MEDICAL STAFF

a. <u>Officers of the Medical Staff</u>: The officers of the Medical Staff shall be the Chief of Staff, Chairperson/President (permanent), the Secretary (elected), and the Secretary-Elect (elected). The administrative organization of the Medical Staff will follow VA regulations.

b. Qualifications: Officers must be members of the active Medical Staff at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

c. Nominations: The annual election of officers will take place in January. A nominating committee will be appointed by the Chief of Staff 30 days prior to the election date. The committee will present a slate of nominees consisting of two or more candidates at the General Medical Staff Conference. Nominations from the floor will be recognized if the nominee is present and consents.

d. Elections: Voting shall be by written or electronic ballot. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Executive Committee of the Medical Staff will decide the election at its next meeting.

e. Term of Elected Office: The Secretary shall serve a one year term, commencing at the first General Medical Staff meeting following the election. Each officer will serve until the end of his/her term, or until a successor is elected, unless he/she resigns or is removed from office. At the end of his/her term the Secretary-Elect shall automatically assume the office of Secretary and a new Secretary-Elect will be chosen.

f. Vacancies in Elected Office: Vacancies in office occur upon the death or disability, resignation or removal of the officer, or such officer's loss of membership in the Medical Staff. Vacancies other than the Chief of Staff will be filled by appointment made by the Executive Committee of the Medical Staff until the next regular election.

g. Removal of Officers: Removal of elected officers from the Medical Staff shall be for cause only and requires a recommendation by the Executive Committee of the Medical Staff and a majority vote by the Medical Staff members. Removal of appointed officers will be in accordance with Department of Veteran Affairs regulations.

7.2 LEADERSHIP

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

b. The Medical Staff, through its committees, Service Chiefs, and program representatives provides counsel and assistance to the Chief of Staff and Medical

Center Director regarding all facets of the patient care services program, including continuous quality improvement, patient safety, goals and plans, mission and services offered.

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

7.3 DUTIES OF OFFICERS

a. The Chief of Staff shall serve as the chief administrative officer of the Medical Staff according to VA regulations to:

(1) act in coordination and cooperation with the Medical Center Director in al matters of mutual concern within the Medical Center;

(2) call, preside over, and be responsible for the agenda of all general meetings of the Medical Staff;

(3) serve as Chairman of the Clinical Executive Board;

(4) appoint committee members to all standing, special and multidisciplinary Medical Staff committees with the advice and consent of the Secretary of the Medical Staff, except the Clinical Executive Board;

(5) be responsible for the enforcement of the Medical Staff Bylaws, Rules, and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated in collaboration with the directors of the clinical divisions;

(6) represent the views, policies, needs and grievances of the Medical Staff to the Medical Center Director;

(7) receive and interpret the policies of the Medical Center Director to the Medical Staff and report to the Medical Center Director on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

(8) be responsible for the educational and quality assurance activities of the Medical Staff; and

(9) be spokesman for the Medical Staff in its external professional and public relations.

b. The Secretary shall:

(1) serve as a member of the Clinical Executive Board;

(2) advise and consent to the appointment of committee members to all standing, special, and multidisciplinary Medical Staff committees with the exception of the Clinical Executive Board;

(3) assist the Chief of Staff in representing the views, policies, needs and grievances of the Medical Staff to the Medical Center Director;

(4) call meetings on the order of the Chief of Staff or the Clinical Executive Board;

(5) excuse absences from the meetings on behalf of the Chief of Staff and Clinical Executive Board.

c. The Secretary-elect shall

(1) assume all the duties of the Secretary in the absence of the Secretary;

(2) perform other duties as requested by the Secretary.

ARTICLE VIII: COMMITTEES

8.1 EXECUTIVE COMMITTEE OF THE MEDICAL STAFF

(Clinical Executive Board) **The Executive Committee of the Medical Staff (CEB) shall meet monthly or at the call of the Chairperson.**

a. Membership

(1) The Medical Center Director or designee is an Ex-Officio member.

(2) The remaining voting membership of the Clinical Executive Board (CEB) shall be the Chief of Staff, Chairperson, Clinical Service Chiefs, Section leads or chiefs, Chief Medical Officers, and the Secretary of the Medical Staff The members are fully licensed physician members of the Medical Staff actively practicing at this facility. Medical Staff members are eligible for membership on the Clinical

Executive Board by serving as the Secretary or Secretary-Elect of the Medical Staff. Ex-officio members participate in meetings; however, they have no vote.

Membership

Chief of Staff (COS) -	Chairperson
Chief of Education	Member
Primary Care Service Chief	Member
Surgery Service Chief	Member
Medicine Service Chief	Member
Behavioral Medicine Service Chief	Member
Extended Care Service Chief	Member
Imaging Service Chief	Member
Pathology and Laboratory Service Chief	Member
Physical Medicine & Rehabilitation Service Chief	Member
Dental Program Section Chief	Member
Secretary, Medical Staff	Member
Lead Emergency Room Physician	Member
Medical Officer EOPC	Member
Medical Center Director or designee	Ex-Officio
Associate Director Patient Care/Nursing Svcs.	Ex-Officio
Associate Chief Nurse, Primary Care/Behav. Med.	Ex-Officio
Associate Chief Nurse, Specialty	Ex-Officio
Associate Chief Nurse, Acute	Ex-Officio
Associate Chief Nurse, Extended Care	Ex-Officio
Pharmacy Service Chief	Ex-Officio
Quality Manager	Ex-Officio
Health System Specialist for Chief of Staff	Ex-Officio
Patient Safety Coordinator	Ex-Officio
Social Work Service Chief	Ex-Officio
Credentialing Office Supervisor	Ex-Officio

b. <u>Functions</u>

(1) Act on behalf of the organized Medical Staff between Medical Staff meetings.

(2) Act to ensure effective communication between the Medical Staff and the Medical Center Director.

(3) Make recommendations directly to the Governing Body (MCD) regarding the:

*** Structure of the Medical Staff,**

*** Mechanisms used to review credentials and delineate clinical privileges,**
*** Recommendation of individuals for Medical Staff membership**
*** Recommendation for delineated clinical privileges for each eligible individual,**
*** Organization of quality improvement activities of the Medical Staff as well as mechanism used to conduct, evaluate, and revise such activities,**
*** Mechanisms by which membership on the Medical Staff may be terminated,**
*** Mechanisms for fair-hearing procedures, and**
*** Medical Staff ethics and self-governance actions.**

(4) receive and act on reports and recommendations from Medical Staff committees including those with quality of care responsibilities, clinical services and assigned activity groups.

(5) Receive, act on and approve criteria for granting clinical privileges for each service.

(6) Functional requirements as delineated in M-1, part I, chapter 1.

(7) Insure professional accreditation is maintained, effecting necessary action for changes in Medical Staff Bylaws, Rules and Policies.

(8) Take reasonable steps to develop and support continuing education activities and programs for the Medical Staff.

(9) Establish the structure of the Medical Staff, the organization of quality management activities and mechanisms of the Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of the organized Medical Staff.

(10) Define circumstances requiring a focus review of a practitioner's performance and evaluation of Bylaws .

(11). Insure that the professional staff of the Medical Center exercises supervision and quality control of the house staff.

(12) Resident physicians/house staff will function only under the direct supervision of a practitioner with appropriate clinical privileges at this medical center and in accordance with resident supervision VHA Handbook 1400.1 Residents' Credentials Verification Letters (RCVL) will be on file in the Chief of Staff's office and credentialing office.

(13). Recommend action to the Dean's Committee of all matters relevant to the functioning of the Dean's Committee.

(14) Review the quality and appropriateness of the services provided by contract physicians, fee basis physicians, and consultants.

(15) Investigate and report on matters referred by the Chief of Staff or the Medical Center Director regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff member.

(16). Identify and manage matters of individual physician health according to defined process separate from medical staff disciplinary function

(17). Evaluate and take action if the performance of a member of the Medical Staff is such that, in the opinion of the Service Chief or the Chief of Staff, the continued exercise of clinical privileges would likely lead to serious harm to the patients under his care.

(18). 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.

(19). Oversees process in place for instances of "for-cause" doubt about a medical staff member's competency to perform requested privileges.

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

(21). Oversees process for fair-hearing procedures consistent with approved VA mechanisms.

(22). Monitors medical staff ethics and self-governance actions.

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

8.2 PROFESSIONAL STANDARDS (Sub-committee of the Clinical Executive Board) ***(Professional Standards Session)*: The following members of the CEB will meet at the call of the Chairperson to consider and make recommendations to the Medical Center Director on professional standards matters, i.e., medical staff appointments; promotion requests; and clinical privilege applications: the Chief of Staff who will serve as Chairperson; all physician members of the CEB; the Credentialing**

Supervisor and credentialing support staff for purposes of recording proceedings/actions, Health Systems Specialist for the Chief of Staff on an ad hoc basis, the Quality Management Coordinator, who will support OPPE/FPPE reviews; and the Personnel Specialist, who will serve as technical advisor and will attend meetings at the request of the Chairperson. Minutes will be approved by the Medical Center Director. Personal attendance is required unless excused by the Chairperson.

Board Functions for Medical Staff

A. Review and act on employment applications and determine whether the 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. Physical 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 approve prescriptive authority and then make recommendation to the PSB for granting of scope of practice for approval of appointment.

4. Selection and Appointment Action

A. The Professional Standards Board will evaluate professional qualifications and recommend a grade and step pay level based on VHA qualification standard requirements. The Board will also recommend a rate of pay with due consideration being given to prior service and professional achievement (VA Handbook 5007, Part II). 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 Standards 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 over the signature of 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 3. 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 5007/21. Appointment actions recommended by the Professional Standards Board require a separate review for a pay recommendation by the appropriate Compensation Panel.

8.3 STANDING COMMITTEES – **The organized medical staff participates in organization-wide performance improvement activities in part through the activities of committees. Staff assigned responsibility for review of committee functions and performance improvement indicators/triggers will report aggregate review**

information and recommendations to CEB.

a. Surgical Quality Assurance Committee
b. Peer Review Committee
c. Pharmacy and Therapeutics Committee
d. Medical Records Committee
e. Transfusion Committee
f. Infection Control Committee
g. Critical Care Committee
h. Extended Care Committee
i. Pain Committee
j. Home Oxygen Committee
k. Academic Affiliations Council
l. Tumor Board
m. Disruptive Behavior Committee
n. Bar Code Medication Administration Committee

General Medical and Directors Staff meetings may contain additional information helpful to the CEB in evaluating care, treatment, and services delivered. It is expected that collaboration across the governance structure as outlined in MCM 306 and 307 will occur for optimal communication and implementation of performance improvement endeavors.

8.4 COMMITTEE RECORDS

a. Committees will prepare and maintain reports of conclusions, recommendations, actions taken and results of actions taken using the CRAE minutes format as outlined in policy. These minutes will be forwarded in a timely manner to the Clinical Executive Board.

b. Committee minutes will provide for appropriate and timely feedback to the service regarding all information pertaining to the service and its providers.

c. The executive summary format for synopsis, report of monitored elements, and recommendations, will be utilized for reporting to CEB with posting to the shared site no more than 7 days prior to the monthly meeting.

8.5 COMMITTEE ATTENDANCE

a. Medical Staff members, or their designated alternates, will attend 50% of meetings of committees of which they are members unless specifically excused by the committee chairperson for appropriate reasons, e.g., illness, leave, clinical requirements, etc. Committee minutes will specify members absent, alternates and members present.

b. If a member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Clinical Executive Board.

ARTICLE IX: CLINICAL SERVICES

9.1 CLINICAL SERVICES CHARACTERISTICS

a. Each service shall be organized as a separate part of the Medical Staff and shall have a physician lead that shall be responsible for the overall supervision of the clinical work within that division according to VA regulations. Each Service or Section Chief will work in collaboration with assigned managers and/or supervisors to execute the functions and responsibilities of the service

b. Each service will hold a monthly staff meeting.

9.2 SERVICE FUNCTIONS

a. Provide for continuous quality improvement within the division including considering findings of ongoing professional practice information from monitoring and evaluation of quality (including access, efficiency, effectiveness); appropriateness of care and treatment to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; performance measures on customer satisfaction; chronic disease and prevention risk management activities; and utilization management.

b. Assist in identification of important aspects of care for the service and applicable functions as defined in TJC Manual, identification of indicators used to monitor quality and appropriateness of important aspects of care and evaluation of the quality and appropriateness of care through peer review processes.

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

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

e. Define/develop clinical privileges statements including levels (or categories) of care.

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

g. Utilize VHA performance measures and monitors as a basis for assessing and improving quality, timeliness, efficiency, and safety of service activities.

9.3 SELECTION AND APPOINTMENT OF SERVICE CHIEFS

Service Chiefs are appointed by the Medical Center Director upon the recommendation of the Chief of Staff, Dean's Committee or Medical Advisory Committee (if appropriate) and with the concurrence of the applicable VACO Program Office. Full time appointment to the VA is criteria for appointment as Service Chief.

a. For each Medical Staff Service Chief the credentials file will document that he or she is a diplomat of a board(s) determined by the Medical Staff to be relevant to the position.

OR

b. If he/she is not board certified, the credentials file will document the determination that he/she possesses the knowledge and skills comparable to those expected of a corresponding diplomat of a relevant board(s).

c. The Chief of Staff, who is also an active practitioner, will have medical staff recommendations following review of credentialing and re-privileging requests, forwarded to the Network CMO for approval prior to consideration by the Medical Center Director.

d. Any member of the PSB being considered for re-credentialing and/or privileges will excuse themselves from the meeting. Any PSB member who may be a subordinate of a Service Chief being considered for re-privileging or credentialing will abstain from voting.

9.4 DUTIES AND RESPONSIBILITIES OF SERVICE CHIEF

The Medical Staff is organized into Services (departments), with a Chief who is certified by an appropriate specialty board or affirmatively established comparable competence through the credentialing process and is appointed full-time. The Service Chief has administrative responsibility for the operation of the Service and clinical and research efforts as are necessary. The Service Chief is compensated under the physician's special pay program. In addition to duties listed below, the Service Chief is responsible for assuring the Service performs according to

applicable VHA performance standards applicable to the Service. 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 spelled out in individual Performance Plans for each Service Chief.

Service Chiefs are responsible and accountable for:

a. All professional clinical, and administrative activities within the care line including selection, orientation and continuing education of staff.

b. Monitoring and evaluating the quality of care provided. This includes access, efficiency, effectiveness and appropriateness of care and treatment of patients served by the programs within the service and the clinical/professional performance of all individuals in the service. The Service Chief will utilize the ongoing professional practice evaluation information in the areas of patient care, medical/clinical knowledge, Practice based learning and improvement, interpersonal and communication skills, professionalism, and systems based practice to evaluate a practitioner and recommend continuance, limitation, or revocation of any existing privilege.

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

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

e. Recommending appointment and clinical privileges for each member of the departments and others requesting privileges within the service and documenting initial competencies using the Focused Pracitioner practice evaluation format per policy.

f. Assessing and recommending off-site sources for needed patient care, treatment and services not provided by the VAMC and associated sites of care.

g. The coordination and integration of interdepartmental and intradepartmental services to include primary functions such as resource recommendations for staffing, space, and equipment as well as strategic planning.

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

i. The determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services

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

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

l. The orientation and continuing education of all persons in the department or service

m. Medical Staff Leadership and Provider Profiling on-line training must be completed within three months of appointment as Service Chief.

n. 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.

ARTICLE X: MEDICAL STAFF MEETINGS

1. The Medical Staff meets as a whole at least quarterly and at the call of the President (COS) or Secretary of the Medical Staff.

2. Regular meetings are convened at the call of the chairperson. Special meetings may be convened at the call of the Medical Center Director, President of the Medical Staff or Secretary of the Medical Staff.

3. Medical Staff members will attend their service staff meetings and meetings of committees of which they are members unless specifically excused by the director or chair for appropriate reasons, e.g., illness, leave, or clinical requirements.

4. Medical Staff members, or their designated alternates, will attend at least 50% of the Medical Staff meetings as a whole unless specifically excused by the chairperson for appropriate reasons, e.g., illness, leave, or clinical requirements.

5. Active members of the Medical Staff are voting members. Consulting/Fee Basis/Contract members of the Medical Staff have no right to vote, except within committees when the right to vote is specified at the time of appointment. (See Article III of these Bylaws).

6. Minutes of all meetings will reflect (at a minimum) attendance, absences, issues discussed, conclusions, actions, recommendations, evaluation and follow up.

7. A quorum for purposes of Medical Staff meetings, committee meetings, and service staff meetings is defined as 50% Active Medical Staff attendance.

8. A majority vote by Active Medical Staff members on any issue constitutes the action of the group.

ARTICLE XI: IMMUNITY FROM LIABILITY

11.1 DEFINITIONS

For purposes of these Bylaws the following definitions shall apply:

a. Information shall mean the record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures, either in written or oral form, that relate to any of the activities described in this article.

b. Malice shall mean intent to harm, either by the dissemination of a knowing falsehood or by the distribution of information without proper regard for its truthfulness or falsity.

c. Practitioner shall mean a medical staff member or an applicant to staff membership.

d. Representatives shall mean the Medical Center Director or designee; the Executive Committee of the Medical Staff; and any authorized member, officer, department, or committee thereof; and any individual authorized by any of the above to perform specific functions of gathering and/or disseminating information.

e. Third Party shall mean individuals or organizations that provide

information to any representative.

11.2 CONFIDENTIALITY AND IMMUNITY

a. Confidentiality of Information. Information with respect to any practitioner that is submitted, collected or prepared by any representative of this or any other health care facility, organization or medical staff for the purpose of achieving and maintaining the quality of patient care shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative or the practitioner or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general hospital records.

b. Immunity. No representative of the hospital or staff shall be liable in any judicial proceedings for damages or other relief for any action taken or statement or recommendation made within the scope of this duties as a representative, if such representative acts in good faith and without malice. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

c. Activities protected. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities concerning, but not limited to:

- **Application for appointment or clinical privileges.**
- **Periodic reappraisals for reappointment or clinical privileges.**
- **Corrective action, including summary suspension.**
- **Hearings and appellate reviews.**
- **Quality Assessment activities.**
- **Utilization Reviews.**
- **Other medical center, departmental, division, committee, or subcommittee activities related to monitoring and maintaining the quality of patient care and appropriate professional conduct.**
- **Other staff functions provided for in these Bylaws.**

d. Releases. Each practitioner, upon application and reapplication for membership and/or clinical privileges shall execute general and specific releases in accordance with these Bylaws and credentialing requirements.

ARTICLE XII: RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws and guidelines of the Governing Body, subject to approval of the Medical Center Director. Such rules shall be a part of these Bylaws. Rules may be changed at any time by pen and ink change and approval by the Medical Executive Committee. Such changes shall become effective when approved by the Director.

ARTICLE XIII: AMENDMENTS

1. The Bylaws, Rules and Regulations are reviewed at least biennially, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of the last review. Proposed amendments to the Bylaws, Rules and Regulations and attendant policies may be submitted in writing to the Chief of Staff by any service chief or member of the Medical Staff. These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment shall be referred to a special committee which shall report on it at the next regular meeting of the Medical Staff or at a special meeting called for such a purpose or by providing a narrative report by mail to the members of the Medical Staff. To be adopted, an amendment shall require a two-thirds vote of the active Medical Staff present at such meetings or two-thirds vote of the active Medical Staff through a mail-out ballot.

2. Written text of proposed significant changes are to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and be notified of the date proposed changes will be considered.

3. All changes to the Bylaws require action by both the Medical Staff and the Medical Center Director. Neither may amend unilaterally.

4. Changes are effective when approved by the Medical Center Director.

ARTICLE XIV: ADOPTION

These Bylaws together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the active Medical Staff at which a quorum is present. They shall replace any previous Bylaws, Rules, and Regulations, and shall become effective when approved by the Medical Center Director.

Adopted by the Medical Staff of VA Medical Center, Marion, Illinois on

April 8, 2010.

RECOMMENDED:

FARHANA HASAN, M.D..
Chief of Staff

APPROVED:

JAMES W. ROSEBOROUGH
Director

RULES AND REGULATIONS
GENERAL MEDICAL STAFF
VA MEDICAL CENTER
MARION, ILLINOIS

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RULES AND REGULATIONS
of the Medical Staff

A. GENERAL

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

2. Rules of the departments or services will not conflict with each other, with bylaws, rules and policies of the Medical Staff or requirements of the Governing Body.

3. The Medical Staff as a whole shall hold at least quarterly meetings. At least 50 percent of the Active Medical Staff are required to attend.

4. The Clinical Executive Board(CEB) serves as the executive committee of the Medical Staff and between meetings, acts in their behalf. The CEB is responsible for continually reviewing the quality of the clinical care carried out in the medical center.

5. 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 ("peer review") of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.

6. Information used in quality improvement will include sentinel event data, patient safety data, and data from adverse privileging decisions, when privileged through the medical staff process.

B. PATIENTS RIGHTS AND RESPONSIBILITIES

I. <u>Respect and Nondiscrimination</u>

- **You will be treated with dignity, compassion and respect as an individual. Your privacy will be protected. You will receive care in a safe environment. We will seek to honor your personal and religious values.**

- **You or someone you choose has the right to keep and spend your own**

money. You have the right to receive an accounting of VA held funds.

- **Treatment will respect your personal freedoms. In rare cases, the use of medication and physical restraints may be used if all other efforts to keep you or others free from harm have not worked.**

- **As an inpatient or Community Living Center resident you may wear your own clothes and keep personal items. This depends on your medical condition.**

- **As an inpatient or Community Living Center resident, you have the right to social interaction, and regular exercise. You will have the opportunity for religious worship and spiritual support. You may decide whether or not to participate in these activities. You may decide whether or not to perform tasks in or for the Medical Center.**

- **As an inpatient or Community Living Center resident, you have the right to communicate freely and privately. You may have or refuse visitors. You will have access to public telephones. You may participate in civic rights.**

- **As a Community Living Center resident, you can organize and take part in resident groups in the facility. Your family also can meet with the families of other residents.**

- **In order to provide a safe treatment environment for all patients and staff you are asked to respect other patients and staff and to follow the facility's rules. Avoid unsafe acts that place others at risk for accidents or injuries. Please immediately report any condition you believe to be unsafe.**

II. <u>Information Disclosure and Confidentiality</u>

- **You will be given information about the health benefits that you can receive. The information will be provided in a way you can understand.**

- **You will receive information about the costs of your care, if any, before you are treated. You are responsible for paying for your portion of the costs associated with your care.**

- **Your medical record will be kept confidential. Information about you will not be released without your consent unless authorized by law (i.e., State public health reporting). You have the right to information**

in your medical record and may request a copy of your records. This will be provided except in rare situations where your VA physician feels the information will be harmful to you. In that situation, you have the right to have this discussed with you by your VA provider.

- **You will be informed of all outcomes of care, including any injuries caused by your medical care. You will be informed about how to request compensation for injuries.**

III. Participation in Treatment Decisions

- **You, and any persons you choose, will be involved in all decisions about your care. You will be given information you can understand about the benefits and risks of treatment. You will be given other options. You can agree to or refuse treatment. Refusing treatment will not affect your rights to future care but you have the responsibility to understand the possible results to your health. If you believe you cannot follow the treatment plan you have a responsibility to notify the treatment team.**

- **As an inpatient or Community Living Center resident, you will be provided any transportation necessary for your treatment plan.**

- **You will be given, in writing, the name and professional title of the provider in charge of your care. As a partner in the healthcare process, you have the right to be involved in choosing your provider. You will be educated about your role and responsibilities as a patient. This includes your participation in decision-making and care at the end of life.**

- **Tell your provider about your current condition, medicines (including over the counter and herbals) and medical history. Also, share any other information that affects your health. You should ask questions when you don't understand something about your care. This will help in providing you the best care possible.**

- **You have the right to have your pain assessed and to receive treatment to manage your pain. You and your treatment team will develop a pain management plan together. You are expected to help the treatment team by telling them if you have pain and if the treatment is working.**

- **You have the right to choose whether or not you will participate in any research project. Any research will be clearly identified.**

Potential risks of the research will be identified and there will be no pressure on you to participate.

- **You will be included in resolving any ethical issues about your care. You may consult with the Medical Center's Ethics Committee and/or other staff knowledgeable about health care ethics.**

- **If you or the Medical Center believes that you have been neglected, abused or exploited, you will receive help.**

IV. Complaints

- **You are encouraged and expected to seek help from your treatment team and/or a patient advocate if you have problems or complaints. You will be given understandable information about the complaint process available to you. You may complain verbally or in writing, without fear of retaliation.**

2. Patient Responsibilities

a. Patient adherence to the published and posted list of responsibilities is necessary to assure the highest quality of care. It also indicates the importance of patient contribution into their own care. Patients are responsible:

(1) to follow all of the Medical Center's safety rules and posted signs.

(2) to try to be considerate and respectful of all medical center personnel and other patients.

(3) to cooperate with the treatment staff and be responsible for discussing it with the staff if there are questions or disagreements with the plan.

(4) to try to prevent injury to themselves, other patients, visitors, and staff members by personal actions and to be responsible for the safekeeping of clothing, money, and personal possessions chosen to keep while in the facility. To refrain from any action done on purposes to hurt or threaten others.

(5) to keep all scheduled diagnostic or treatment appointments on time.

(6) to avoid interfering with the treatment of other patients particularly in emergency situations.

(7) to assist by alerting the staff when another patient is having any difficulty.

(8) to tell visitors to be considerate of other patients and medical center personnel and to observe the visiting hours.

(9) to be understanding and patient if they encounter delays.

(10) to make sure they understand what medications they should take and follow discharge instructions and know about scheduled follow up visits.

b. Regarding pain management patients are responsible for:

(1) asking the doctor or nurses what to expect regarding pain and pain management.

(2) discussing pain relief options with the healthcare provider.

(3) asking for pain relief medication at first onset

(4) assisting the staff in measuring the level of pain experienced.

(5) telling healthcare providers if pain is not being relieved.

3. <u>Advanced Directives</u>

a. 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, as 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 provision of life-sustaining treatment, such treatment will be withdrawn.

b. The patient's right to direct the course of medical care is not extinguished by the loss of decision-making capability. In order that this right may be respected in cases involving such patients, VA recognizes the right of an adult person to make an advance directive in writing concerning all treatment, including life-sustaining treatment.

4. <u>Informed Consent</u>

a. An informed consent for operative and other invasive procedures, therapeutic or diagnostic, and blood transfusions, when required, shall be obtained from the patient, legal representative or next of kin. Should the patient's condition preclude the ability to give informed

consent, and, if by using all reasonable means available, the legal representative or next of kin cannot be located, appropriate policies set forth by the VA shall be followed. The consent form to be signed by the patient/surrogate will clearly indicate the name of the procedure, site of the procedure, and laterality when applicable and reason for the procedure. Abbreviations will not be used in the consent form.

b. The consent of the patient, legal representative or next of kin, as appropriate, for surgery, diagnostic and/or therapeutic procedures, implies that patient, legal representative or next of kin understands the procedure anticipated; understands the reason for which the procedure is recommended, the options, the degree of disability/risk which may reasonably be expected to ensue and understands the benefits which may be expected. Assuring informed consent from the patient is obtained, is the responsibility of the medical staff member legally responsible for the patient's care. Actual signature may be received from any medical staff member, mid-level provider or assigned licensed healthcare practitioner (RN, Radiology Tech., Physical Therapist, etc.) given the name of the provider performing the procedure is named on the consent and explanation of risks, benefits and options are discussed by the primary provider. (MCM 43, *Informed Consent for Administration of Anesthesia and for Performance of Therapeutic and Diagnostic Procedures and Blood Transfusions* and MCM 558, *Surgical Site Verification.*

5. <u>Ethics Consultation</u> – any healthcare provider may request consultation regarding an ethical issue or dilemma. A patient or family may ask for the advice of the Ethics Consultative Committee. Access to the committee is open to all who are involved in health care decision making (MCM 218, *Integrated Ethics Program*).

C. GENERAL RESPONSIBILITY FOR CARE

1. <u>Conduct of Care</u>

a. Management of the patient's general medical condition is the responsibility of a qualified licensed independent practitioner with appropriate clinical privileges as a member of the Medical Staff.

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

c. There will be the same level of quality of surgical and anesthesia care throughout the medical center.

2. Emergency Services

a. The designated level of emergency services at this medical center using Joint Comission Levels is Level IV.

b. Medical emergency treatment shall be provided to any applicant presenting for treatment, who is in danger of loss of life or limb. Seriously ill and unstable patients, will be stabalilzed and transferred to the nearest VA or community facility with the services required by acuity and needs determination of the provider.. Patients who are not eligible for VA care will be referred to another medical facility which can provide adequate care as soon as medically indicated.

c. There shall be a licensed physician on duty and available at all times to the admitting area.

d. A call schedule will be maintained so that all patients have immediately available a physician and/or dentist to attend them for any emergency which might occur at night or during non-regular duty hours.

e. Eligible applicants who are not in need of emergent/urgent care will be provided necessary medical care and/or scheduled in an appropriate primary care clinic. Applicants who are not in need of emergent care and who are not eligible for VA care will be referred to another medical facility that can provide adequate care for the medical problem.

f. Eligible applicants seen by both VA and community providers will be assigned to, followed and managed by a VA primary care clinician/team, even if some of the care is provided in the community as outlined in MCM 553, *Guidelines for the Care of Patients Seen by Both VA and Community Providers (Co-Managed Care).*

3. Co-Managed Care

a. MCM 553, *Guidelines for the Care of Patients Seen by Both VA and Community Providers (Co-Managed Care)*

b. VHA Directive 2002-074: VHA National Dual Care Policy

4. Admissions

a. Individuals with admitting privileges will be members of the Medical Staff or others with privileges to admit.

b. Criteria for Standards of Medical Care

(1) There shall be prompt medical evaluation for those patients admitted by non physicians.

(2) The medical center shall admit legally eligible patients suffering from any type of disease which, in the opinion of the admitting member of the Medical Staff, can be adequately cared for at this medical center, and shall admit and treat any person for humanitarian purposes until such time as the patient may be safely transferred to another hospital.

(3) All practitioners shall be governed by the official admitting policy of the medical center and precertification criteria as established by InterQual.

(4) Except in an emergency, no patient shall be admitted to the medical center until a provisional diagnosis or valid reason for such admission has been stated in the medical record. In the case of an emergency, such statement shall be recorded as soon as possible.

(5) All patients shall be attended by members of the Medical Staff, and shall be assigned to that section of the division concerned with the treatment of the disease which necessitated admission. The patient shall be under the care of the practitioner assigned to that specific section at the time of admission.

(6) Each patient shall be the responsibility of a member of the Medical Staff. Such practitioner shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports on the condition of the patient to their relatives. When acting in the capacity as supervisor of practitioners in training, the medical staff members shall be responsible for assuring that these delegated responsibilities are performed in an adequate and timely manner.

(7) With the exception of emergencies, transfers from one section to another shall be done only by written consent of both practitioners concerned. This written consent of both parties shall be incorporated in the medical record.

(8) On admission, all drugs brought into the medical center by patients will be removed unless there is a specific order written by the physician allowing the patient to utilize previously prescribed drugs. The procedure outlined in Medical Center Memorandum No. 432, *Medications Released by Patients on Admission*, will be followed.

(9) The management of pain is appropriate for all patients, not just dying patients and will be accomplished according to accepted medical standards, patient rights, and responsibilities.

c. <u>H&P (History and Physical) Examination</u> (MCM 138, *Medical Record Completion Requirements)*

(1) The H&P will be performed by a physician who has such privileges within 24 hours of admission. H&Ps may also be done by resident physicians physician assistants or nurse practitioners, who are permitted to do so based on job description or scope of practice statement with co-signature by a qualified physician. A complete admission history and physical examination shall be recorded within 24 hours after receiving the patient. The elements of the H&P as approved by the medical staff include chief complaint, history of present illness, past medical history, social history, review of systems, medications, allergies, with physicial examination categories including General, HEENT, Neck, Lungs, Cardiovascular, Abdomen/Pelvis, Extremities, Neurological, Diagnostic Tests: abnormals, Impressions/Plan.

(2) Other individuals (PA or NP) permitted to perform H&Ps must provide for confirmation or endorsement of findings, conclusions and assessment of risk by a qualified physician prior to major high risk (defined by Medical Staff as class 4 or 5 ASA classification) diagnostic or therapeutic intervention.

(3) A patient admitted by a physician other than the primary care provider may write an admission note which documents pertinent information relative to the patient's complaints, findings, and initial are to supplement the assessment of the attending. When a complete history and physical examination has been recorded within 30 days prior to admission to the medical center, these reports may be used in the patient's medical record provided these reports were recorded by a practitioner on the staff or in training at this medical center. In such instances, an admission note on a doctor's progress sheet must be written to include all additions to the history and any subsequent changes in the physical findings. The interval history and physical may also be used if the patient is readmitted within 30 days for the same or related problems.

(4) Patients admitted to the hospital for dental or podiatry care must be given the same careful medical appraisal as those admitted for other services, and a physician member of the Medical Staff will be responsible for the care of the patient throughout the hospitalization.

(5) Qualified oral and maxillofacial surgeons may perform the medical history and physical examination if they have such privileges in order to assess the medical surgical and anesthetic risks of the proposed Operating Room. or other procedures.

Dentist's Responsibilities

(1) A detailed dental history justifying admission.

(2) A detailed description of the examination of the oral cavity and preoperative diagnosis.

(3) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the number of teeth and fragments removed shall be clearly stated. All tissue, including teeth and fragments, shall be sent to the medical center pathologist for examination.

(4) Progress notes pertinent to the oral condition.

(5) The discharge summary.

Podiatrist Responsibilities

(1) A detailed podiatrist history justifying admission.

(2) A detailed description of the examination of the feet and preoperative diagnosis.

(3) The part of the patient history and physical examination that relates to podiatry.

(4) A complete podiatric operation report.

(5) Progress notes pertinent to the podiatric condition.

(6) The discharge summary.

Physician's Responsibilities for Dental or Podiatry Patients

(1) Medical history pertinent to the patient's general health.

(2) A physical examination and laboratory, x-rays and EKG studies, as appropriate, to determine the patient's condition prior to anesthesia and surgery.

(3) Supervision of the patient's general health status while hospitalized.

(4) Available for response during intra-operative emergency or need for consultation.

d. Procedures

Patients will be assigned to the care of members of the Medical Staff who are responsible for:

(1) Medical care and treatment.

(2) Prompt completion and accuracy of the medical record.

(3) Special instructions.

(4) Transmitting reports on the condition of the patient to referring practitioner and the patient's family members.

(5) Except in an emergency, not admitting until after admitting diagnosis is entered in the medical record.

e. Tests

(1) There will be no "routine admission orders" for laboratory, x-ray or other diagnostic studies. Such studies will be performed only when ordered in writing by a responsible professional with appropriate clinical privileges at this medical center.

(2) An informed consent for surgery, therapeutic or diagnostic procedure, when required, shall be obtained from the patient, legal representative or next of kin. Should the patient's condition preclude the ability to give informed consent, and, if by using all reasonable means available, the legal representative or next of kin cannot be located, appropriate policies set forth by the VA shall be followed. Consent for HIV testing will be carried out according to VA Regulations and local policy (MCM 470, *HIV (Human Immunodeficiency Virus) Program*).

(3) The consent of the patient, legal representative or next of kin, as appropriate, for surgery, diagnostic and/or therapeutic procedures, implies that patient, legal representative or next of kin understands the procedure anticipated; understands the reason for which the procedure is recommended; the options; the degree of disability which may reasonably be expected to ensue; and understands the benefits which may be expected. Obtaining such an informed consent from the patient is the responsibility of the medical staff member legally responsible for the patient's care (MCM 43, *Informed Consent for Administration of Anesthesia and for Performance of Therapeutic and Diagnostic Procedures and Blood Transfusions*).

f. Areas of Restricted Admissions

(1) Areas of restricted bed utilization and assignment of patients shall be the Intensive Care Unit and the Community Living Center (CLC). If any question as to the validity of discharge from these units should arise, that decision will be made through consultation with the appropriate division director or designee.

(2) Responsibilities of Unit Director: Refer to Medical Center and program Memorandums- *Intensive Care Unit Medical Management, Policies of the ICU and Community Living Center Medical Management for admission criteria, procedures for assessment, documentation, and medical management.*

5. Transfers

a. The medical center shall admit legally eligible patients suffering from any type of disease which, in the opinion of the admitting member of the medical staff, can be adequately cared for at this medical center and for which appropriate services are available. The medical center shall admit and treat any person for humanitarian purposes until such time as the patient may be safely transferred to another hospital. The determination of legal eligibility is defined by law and by the Department of Veterans Affairs.

b. Responsibility for patient during transfer both to and from medical center: Refer to MCM 175, *Guidelines for Transfer of Patients by Helicopter, Fixed Wing Aircraft or Ambulance* , .

c. It is the responsibility of the attending physician to write or dictate a discharge summary on all medical records prior to discharge or transfer to another healthcare facility. The summary will include condition of the patient at the time of discharge/transfer, medications, limitations, diagnosis, and all other pertinent medical or social information to assist the accepting physician in providing care for the patient. This information will accompany the patient being transferred to another healthcare facility. Preparation of the summary and other medical information will be in accordance with VA requirements (M-1, Part 1, Chapter 5). The medical center Transfer Liaison can be contacted for assistance in providing contact and continuity for the transfer activity.

d. Transfer to and from Special Care Units: With the exception of emergencies, transfers from one section to another shall be done only by written consent of both practitioners concerned (transferring physician and accepting physician). This written consent will be recorded in the medical record. If there is any question as to the validity of admission or discharge from a special care unit, the decision will be made through consultation with the appropriate division director and unit director.

e. Interfacility Coordination Policy: VHA Directive 2007-016 – *Coordinated Care Policy for Traveling Veterans* – Eligible veterans receiving care at more than one VA facility must have that care coordinated by the preferred facility.

6. Consultations

Philosophy: The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness,

and the question of doubt as to the diagnoses and treatment, rest with the practitioner responsible for the care of the patient. However, it is the duty of the organized medical staff, through its service chiefs and officers, to see that those with clinical privileges do not fail in the matter of calling consultants as needed.

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.

a. A satisfactory consultation includes examination of the patient and the medical record. A written opinion and recommendations 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 surgery.

b. Consultation is suggested in accordance with this organization's published Clinical Practice Guidelines and service agreements for referral/consultation in the following situations:

(1) When the patient is not a good risk for operation, diagnostic procedure, or treatment;
(2) When the diagnosis is obscure after ordinary diagnostic procedures have been completed;
(3) When there is doubt as to the choice of therapeutic measures to be utilized;
(4) In unusually complicated situations where specific skills of other practitioners may be needed;
(5) In instances where the patient exhibits psychiatric symptoms, inappropriate emotional responses or suicidal ideation; or
(6) When requested by the family.

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. The ordering of consults and its timely completion are to follow Advanced Clinical Access guidelines and service agreements

c. <u>Time limits for completion of consultation in</u>:

(1) <u>Emergency</u>: Same day as request. Any patient known or suspected to be suicidal must have immediate and prompt consultation by a member of the clinical psychology/psychiatry staff.

(2) Preoperative: Except in an emergency, the consultation shall be completed prior to the operation.

(3) Routine: For inpatients, 24 hours; for outpatients, first available appointment.

7. Discharge Planning (MCM 151, *Discharge Planning* and MCM 540, *Referrals for Home Care Services).*

a. Initiation of Planning and Continuity of Care: Effective discharge planning begins at the time of admission and is provided to those patients whose diagnoses, disabilities or psychosocial circumstances require interdisciplinary evaluation to assure that the patient is discharged only when all indicated medical, nursing, or home care needs have been arranged in advance of the patient's release. All members of the interdisciplinary treatment team are responsible for the identification and assessment of patients needing discharge planning, referring those patients to other clinical services in a timely manner and providing consultation and assessment of the patient's medical, nursing, psychological, rehabilitation and social needs from their professional prospective. Each discipline is responsible for recording assessment, recommendations and/or disposition in the patient's medical record as required by M-1, Part 1, Chapter 5.

b. Patients will be discharged only on the order of the attending member of the medical staff. Should a patient leave the medical center against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

c. Criteria for Discharge Planning: Refer to Medical Center Memorandum 151, *Discharge Planning*.

8. Discharge

a. Criteria: A patient may be discharged from hospital or CLC on the written order of a licensed health care practitioner with appropriate clinical privileges or scope of practice statement and when comprehensive discharge planning with all indicated medical, nursing, and/or home needs arranged in advance of the patient's release is completed.

b. Discharge from Special Care Units: Patients will be discharged from special care units only on the written order of the attending physician and based on the patient's response to the plan of care in that setting. Questions of validity of discharge from a special care unit will be referred to the appropriate care line director and/or the unit director.

c. Discharge from PACU (Post Anesthesia Care Unit): The provision of anesthesia care by qualified nurse anesthetists will be under the overall supervision of the Anesthesiologist and Chief of Surgery and under the direct supervision of the staff surgeon responsible for the patient's care. Discharge from PACU will be based upon Medical Staff approved criteria by PACU trained staff with concurrence if deemed necessary from the attending surgeon and/or CRNA. (MCM 416, *Post-Anesthesia Care Unit (PACU)*).

d. Discharge from Sam Day Surgery (SDS): The patient will be monitored in SDS unit until all applicable discharge criteria are met as outlined in MCM 170, *Guidelines for Performing Ambulatory Surgery.*

9. Autospy

Refer to : **Refer to MCM 501, *Autopsy Services.***

a. Criteria that identifies deaths in which autopsy should be performed (MCM 501) and;

b. Use of autopsy findings in quality improvement activities (MCM 501).

10. Submission of Surgical Specimens

a. Surgical case review is performed every other month by those programs performing surgical procedures to help assure that surgery is justified and of high quality. (MCM 205) Surgical Quality Assurance Committee.

b. Surgical case review is conducted for each case, whether or not a tissue or non-tissue specimen is removed.

11. Special Treatment Procedures

a. DNR – (MCM 197, *Do Not Attempt Resuscitation (DNAR) and Limitation of Therapy* and MCM 131, *Withdrawal of Life sustaining Treatment)*

b. Protective Security (MCM 42, *Restraints*, MCM 143, *Doctors Orders)*

(1) PRN orders for any type of restraining device will not be written.

(2) Restraint orders will include date and time the order is written, type of restraint, rationale for use, and length of time to be used and/or when device may be removed.

c. Emergency Commitment (MCM 135, *Involuntary Hospitalization of Psychiatric Patients;* MCM 290, *Disturbed Behavior Committee*; MCM 534, *Violent Behavior Prevention* Program; MCM 488, *Substance Abuse and Dependency Services.*

d. Convulsive Therapy: Electro-convulsive therapy and other forms of convulsive therapy are not provided at this facility.

D. PHYSICIANS' ORDERS **(MCM 143 and MCM 182)**

E. ROLE OF ATTENDING STAFF

1. Supervision of Residents and Non-Physicians: M-2, Part 1, Chapter 26; MCM 506, *Supervision of Postgraduate Residents*; VHA Handbook 1400.1, *Resident Supervision.*

a. Mechanisms by which house staff are supervised by members of the Medical Staff in carrying out their patient care responsibilities: Refer to: **M-2, Part 1, Chapter 26, and MCM 506, *Supervision of Postgraduate Residents.***

b. A non-physician health professional is an individual authorized by license or certification to make independent clinical judgments, or perform clinical procedures, or both, within the scope of his/her license and within the scope of their individual practice/functional statement or clinical privileges. Non-physician health professionals may be granted clinical privileges at the discretion of the Clinical Executive Board providing all credentialing requirements are met.

c. In this medical center the following classes of non-physician health professionals will require clinical privileges and must meet all requisites for credentialing: clinical psychologists, optometrists, podiatrists, dentists.

2. Documentation of Supervision, M-2, Part 1, Chapter 26, Par. 26.04(d) and MCM 506, *Supervision of Postgraduate Residents.*

F. MEDICAL RECORDS - **(MCM 138, *Medical Record Completion Requirements)***

1. <u>Basic Administrative Requirements</u>

a. All clinical entries in the patient's medical records shall be legible, accurately dated (month, day and year) and authenticated. Authentication means to establish authorship by written signature or approved electronic signature if the note entered via computerized medical record. Timing of entries is encouraged to establish chronological order to events in the medical record.

b. The medical staff practitioner shall be responsible for the preparation of a comprehensive medical care record for each patient in their care or, in the instance where the medical staff practitioner acts in the capacity of supervisor for practitioners in training, the medical staff practitioner shall be responsible for assuring that these practitioners in training prepare a complete and legible medical record for each patient in their care.

c. Use of Abbreviations and Symbols: MCM 060, *Unapproved Abbreviations*. For patient safety and adherence to standards, the unapproved abbreviation list will be utilized.

(1) Final diagnosis and complications must be recorded without the use of abbreviations or symbols.

d. Diagnostic and therapeutic procedures reports must be completed and entered in the medical record within 24 hours, if possible.

e. <u>Release of Information</u>: MCM 087, *Release of Medical Information*.

f. <u>Removal of Medical Records</u>: Medical records may be removed from the medical center's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute, or with the written permission of the Program Manager for Health Administration Services, when acting in accordance with established rules and regulations of this medical center and the Department of Veterans Affairs.

g. Patient rights to the privacy and security of information as required by HIPAA (Health Insurance Portability & Accountability Act of

1996) as well as Privacy Act of 1974, Federal regulations and MCM IS-85 will be observed.

2. Basic Patient Information Requirements

a. Each medical record shall contain the following basic patient information:

(1) Patient identification (name, address, date of birth, next of kin, and social security number).

(2) Medical history including history and details of present injury/illness and as appropriate, evaluation of abuse, assault or neglect (MCM 106, *Reporting of Abuse and* Neglect)

(3) Observations, including results of therapy.

(4) Diagnostic and therapeutic orders. (MCM 143, *Doctors Orders*)

(5) Report of procedures, tests, and their results.

(6) Progress notes. (MCM 184, *Procedures for Documentation of Progress Notes*)

(7) Consultation reports.

(8) Conclusions at termination of hospitalization, evaluation or treatment.

(9) Informed consent before procedures or treatments are undertaken and if not obtainable, the reason. (MCM 43, *Informed Consent for Administration of Anesthesia and for Performance of Therapeutic and Diagnostic Procedures and Blood Transfusions*); (MCM 470, *HIV (Human Immunodeficiency Virus) Program*)

3. Inpatient Medical Records: Inpatient records will contain all of the information listed in the text above and in addition the following elements:

a. A complete admission history and physical examination shall be recorded within 24 hours after receiving the patient. This report shall include chief complaint, history of present illness, past medical history, social history, review of systems, medications, allergies, with physicial examination categories including General, HEENT, Neck, Lungs, Cardiovascular, Abdomen/Pelvis, Extremities, Neurological, Diagnostic Tests: abnormals, Impressions/Plan as defined by the medical staff. When a complete history and physical examination has been recorded within a week prior to admission to the medical center, these reports may be used in the patient's medical record in lieu of the admission history and report of physical examination, provided these reports were recorded by a practitioner on the staff or in training at this medical center. In such instances, an

internal admission note that includes all additions to the history and any subsequent changes in the physical findings, must always be recorded. The interval history and physical may also be used if the patient is readmitted within 30 days for the same or related problem. Reassessment is completed according to Medical Center Memorandums No. 149 *Primary Care Services* and 21 *Admission to Hospital Care.*

b. <u>Exceptions</u>:

(1) Any patient admitted by a physician other than the primary care provider shall have an admission note in the chart by the admitting physician providing pertinent information relative to the patient's complaints, findings, and initial care. This note is to be completed at the time of admission and will be used by the attending to supplement the overall plan of care.

(2) When the history and physical examination is not completed and recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless such delay would be detrimental to the patient. The medical record will include a preoperative note. The preoperative note shall include the diagnosis, intended operation, and indication of concurrence with the intended surgical procedure on the part of the consultant or member of the medical staff responsible for the care of the patient.

(3) If the history and physical have been dictated but not transcribed, a preoperative note by the attending surgeon, which includes all pertinent findings shall be accepted in emergency cases. Both the nurse in charge and the anesthetist will confirm that such documentation has been done. Neither anesthesia nor surgery are to be started until the above has been accomplished.

c. Conclusions or impressions drawn from the H&P.

d. Planned course of action.

e. (MCM 464, *Discharge Instructions, VAF 10-7978M*).

f. Death Note.

g. Autopsy (MCM 501, *Autopsy Services*).

h. Against Medical Advice.

i. Clinical Resume to include the reason for hospitalization, the significant findings, the procedures performed, treatment

rendered, the patient condition on discharge, and specific instruction given to the patient and/or to significant other as pertinent.

j. Chart must be completed within 30 days of discharge.

4. Outpatient and Emergency Area Medical Record (MCM - 430, *Patient Problem Lists*)

a. Frequency of notes: each patient visit or treatment
b. Relevant history of illness or injury and physical findings including vital signs.
c. Diagnostic impression.
d. Patient disposition and instruction for follow-up care.
e. Immunization status, as appropriate.
f. Allergies.
g. Referrals and communications to other providers.
h. Problem List.
i. Content and timeliness of description of surgical procedures.

5. Additional Requirements for records of patients treated in the Emergency Area

a. Time and means of arrival.
b. Care received prior to arrival.
c. Condition at discharge.
d. Information reference to patient's leaving AMA.

6. Operating Room Record - Must contain the following:

a. Preoperative notes.
b. Workup and exceptions.
c. Diagnosis.
d. Anesthesia evaluation. (PACE clinic findings Preoperative with re-evaluation just prior to induction)
e. Intraoperative documentation.
f. Evaluation of postoperative status on admission to and discharge from Post Anesthesia Recovery and documentation requirements for discharge.
g. Operative reports dictated or entered in the medical record IMMEDIATELY **after surgery.**

7. Documentation requirements regarding *Organ And Tissue Procurement*).(MCM 473)

a. Organs or tissue obtained from a living donor for transplantation.

b. Cadaveric organs or tissue removed for donation.

8. <u>Medical Record requirements relative to special programs of the facility</u>

a. Behavioral Medicine Service (MCM 141, *Referral for Psychiatric/Mental Health Services*, MCM 455, *Outpatient Behavioral Medicine Services*, 488 *Substance Abuse and Dependency Services*).

b. Community Living Center (CLC) Medical Management SOP (Ex-10-09) and record review grid.

c. Respite Care Program (MCM 454, *Respite Care Program*).

d. Mammography Screening (MCM 507, *Mammography(Breast) Screening*).

e. Hospice Services (MCM 191, *Palliative Care Services*)

G. INFECTION CONTROL

1. Standard Precautions, Resistant Organisms (MCM 441, *Blood Borne Pathogens Exposure Control Plan for the Prevention of Transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus, and Other Blood Borne Diseases*; MCM 413, *Isolation* Precautions; and MCM 421, *Resistant Organisms*)

2. Human Immunodeficiency Virus {HIV}

(MCM 441, *Blood Borne Pathogens Exposure Control Plan for the Prevention of Transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus, and Other Blood Borne Diseases*; MCM 445, *Notification and Body Substance Precautions for Patient Transfers to Other Facilities;* and MCM 470, *HIV(Human Immunodeficiency Virus) Program.*

3. Reporting of Communicable Diseases (MCM 125)

4. Tuberculosis Control Program (MCM 512)

5. Infection Control Committee (MCM 204)

6. Preventive Medicine Program for Immunizations(MCM 104)

7. Diagnostic Skin Testing MCM 417)

8. Procedures for Handling Used Needles/Syringes and Small Sharp Instruments (MCM 453)

9. Latex Sensitivities (MCM 523)

H. DISASTERS

1. In the event of a disaster, assignments for the medical staff will contain an assignment to post, either in the medical center or in mobile casualty stations, and it is their responsibility to report to their assigned post when needed. The Chief of Staff and the Medical Center Director will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another or evacuation of hospital premises, the Chief of Staff will authorize the movement of patients as directed by the Medical Center Director or his designee. All policies concerning patient care will be a joint responsibility of the Chief of Staff and the Medical Center Director and in their absence, the Service Chiefs. All members of the medical staff will follow the procedures outlined in the Medical Center Disaster Plan. The Safety Section is responsible for the development of the disaster plan. The plan for the care of casualties will be rehearsed at least twice a year by medical center personnel.

2. Refer to the Medical Center Disaster Plan for specific details for each service and area of the medical center. A copy is available in each Division or from Safety Section. (See disaster privileges section of Bylaws.)

3. A copy of the VA/DOD Contingency Plan is located in Health Administration Program (136) and is available upon request.

I. 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 this medical center can be documented at the time of reappraisal and re-privileging.

J. PEER REVIEW FOR QUALITY IMPROVEMENT

1.. All Medical Staff members shall participate in the medical center protected peer review program established by VHA Directive 2008-004, Peer Review for Quality Management.

2.. All Medical Staff members will complete ongoing required training associated with VHA Directive 2008-004.

K.... **IMPAIRED PROFESSIONAL PROGRAM**

1. The medical center will provide help to impaired professionals through the Employee Assistance Program. (MCM 452, *Employee Assistance Program*). Education of Medical Staff about illness and impairment recognition issues specific to physicians will occur at least annually (MCM 645, *Medical Staff Declaration of Health)*. Management of matters of individual physician's health is a separate process from the medical staff disciplinary function with the purpose of assistance and rehabilitation. 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 to protect the confidentiality of the individual referred for assistance will be made.

Medical Center Memoranda are considered an extension of the Rules. They are available to all staff directly through the Veteran Information Systems Technical Application (VISTA).

MEDICAL STAFF RULES AND REGULATIONS

Reviewed, revised, approved and adopted by the Medical Staff, VAMC Marion Illinois this 8 Day of April 2010.

Farhana Hasan, MD
Chief of Staff

Date 4/12/10

James W. Roseborough
Medical Center Director

Date 4/14/10