

**BYLAWS, RULES AND REGULATIONS OF THE MEDICAL STAFF  
RICHARD L. ROUDEBUSH VA MEDICAL CENTER  
INDIANAPOLIS, INDIANA  
Revised January 2013**

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## **PREAMBLE**

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the Richard L. Roudebush VA Medical Center (RLR VAMC), Outpatient Centers and Domiciliary Unit hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs, Veterans Health Administration (VHA), and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the VHA, and they do not create any rights or liabilities not otherwise provided for in laws or VHA Regulations.

## **DEFINITIONS**

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

1. 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 has delegated authority to the Medical Center Director.
2. Medical Center Director: The Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS), and the Executive Committee of the Medical Staff.
3. Affiliation Partnership Council: A committee established by a formal memorandum of affiliation between the Roudebush VAMC and the Indiana University School of Medicine and approved by the Under Secretary for Health: composed of deans and senior faculty members of the affiliated medical, dental, nursing schools and other academic institutions as appropriate, representative(s) of the medical staff of the RLR VAMC; and such other faculty of the affiliated schools and staff of the RLR VAMC as are appropriate to consider and advise on development, management and evaluation of all educational, research, and clinical programs conducted at the facility.
4. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, Mid-level and/or patient care services at the facility. Both VA employees and contractors providing patient care services as licensed independent practitioner must receive appointments to the Medical Staff.
5. Practitioner: A physician, dentist, podiatrist, optometrist, psychologist or chiropractor who is fully licensed to practice in a State, Territory or Commonwealth of the U.S. or District of Columbia will be referred to as a Practitioner in these Bylaws. All other health professionals in the RLR VA Medical Center will practice under a position description, functional statement and/or scope of practice statement.
6. RLR VAMC Medical Center Memorandum (MCM): Local documents containing policy statements, supporting documentation and mandatory procedural material pertaining to the Richard L. Roudebush Veterans Administration Medical Center. The stated purpose must affect the entire facility; required by an accreditation or regulatory authority, Federal, State, local law or statute; required by the Medical Center Director; or failure to have a policy would result in significant increase of risks to patients, visitors, employees guests or facility infrastructure.
7. Medical Staff: Fully licensed independent physicians, dentists, psychologists, optometrists, podiatrists and chiropractors permitted by law and the Facility to provide patient care Services independently in the Facility, its satellite clinics and outreach facilities.

8. VA Regulations: The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws. (Example: Code of Federal Regulation (CFR) 38 7402).
9. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e., exercise control or impart knowledge, skill or attitude to another Practitioner to ensure appropriate, timely and effective patient care, the action constitutes supervision.

## **ARTICLE I. NAME**

The name of this organization shall be the Medical Staff of the Richard L. Roudebush VA Medical Center.

## **ARTICLE II. PURPOSE**

The purposes of the Medical Staff shall be to:

1. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.
3. Establish and assure adherence to ethical standards of professional practice and conduct.
4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the Medical Center Director in developing and maintaining rules for Medical Staff governance and oversight.
8. Provide a medical perspective, as appropriate, to issues being considered by the Medical Center Director.
9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.
10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.
11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
12. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. The staff will cooperate with affiliated medical schools and other institutions of higher learning in undergraduate, graduate and postgraduate education in both medical and allied health education. The staff will encourage the intellectual interests of its members in basic and clinical research. Care will be taken to appropriately document supervision of resident physicians and other trainees.

13. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational publications.

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

### **Section 3.01 Eligibility for Membership on the Medical Staff**

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, dentists, psychologists, podiatrists, optometrists and chiropractors who continuously meet the qualifications, standards, and requirements of VHA, this Facility, and these Bylaws.
2. Categories of the Medical Staff:
  - a. Active staff who are employed by the VAMC on a half-time basis or greater or any who hold official administrative appointments. Attendance at medical staff meetings and respective service staff meetings is required for this category unless excused. Active staff members are expected to periodically participate in peer review activities, clinical committees and medical staff monitoring activities.
  - b. Consulting staff members employed on a less than a half-time basis by any appropriate VA reimbursement mechanism or without compensation. These members are encouraged to attend meetings of the medical staff; however, attendance shall not be mandatory because of the frequently intermittent nature of their clinical activities at this hospital.
  - c. Assigned duties from Section Chiefs and/or Service Chiefs are to be performed by all VA-employed physicians, both full-time and part-time.
3. Decisions regarding Medical Staff membership are made without discrimination for reasons such as race, color, religion, national origin, gender, sexual orientation, lawful partisan political affiliation, marital status, physical or mental handicap when the individual is qualified to do the work, age, membership or non-membership in a labor organization, or on the basis of any other criteria unrelated to professional qualifications.

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

1. Criteria: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial:
  - a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required for appointment under applicable employment authorities.
  - b. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine, Osteopathy, or Dentistry from an approved college or university.
  - c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training.
  - d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying.

- e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.
  - f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VII or VIII or of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff.
  - g. Satisfactory findings relative to previous professional competence and professional conduct.
  - h. English language proficiency.
  - i. Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.
  - j. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver's license or passport)
  - k. Participate in continuing education.
  - l. Reside in a geographic location within a reasonable commuting time, as applicable for those individuals to be appointed to the active medical staff, half time or greater.
  - m. Background Screening: Applicant must complete fingerprinting and initiate a U.S. Office of Personnel Management background screening for medical staff appointment at the Roubidoux VA Medical Center. A grace period of 60 days from initial appointment date and the granting of clinical privileges will be allowed to initiate the background screening process. The applicant will be notified of any discrepancies or adverse reports discovered from the background screening by Human Resource Management Service.
2. Clinical Privileges and Scopes of Practice: While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent Practitioners are permitted by this Facility and these Bylaws to practice independently.
- a. The following Practitioners will be credentialed and privileged to practice independently and serve as members of the medical staff:
    - i) Physicians
    - ii) Dentists
    - iii) Psychologists
    - iv) Podiatrists
    - v) Optometrists
    - vi) Chiropractors
  - b. Health care professionals enrolled in an a professional training program may be appointed and granted clinical privileges or scope of practice to function outside of their training program in a field for which they meet competency and qualification standards. The appointment must not violate their training program requirements.
  - c. Health care practitioners functioning solely as Lecturer, Researcher, or Instructor, who are not providing or responsible for patient care, must apply and be approved for a Medical Staff appointment. Clinical privileges are not required for these occupations.
  - d. The following practitioners will be credentialed and will practice within a Collaborative Practice Agreement or Scope of Practice with a fully credentialed and clinically privileged medical staff member at this facility:
    - i) Advanced Practice Nurses – Reference RLR VAMC Medical Center Memorandum
    - ii) Physician Assistants – Reference RLR VAMC Medical Center Memorandum

e. All other licensed, registered or certified health care practitioners will be credentialed, as per VHA Directive 2012-030, and will practice under a scope of practice or position description with appropriate supervision. This includes health care practitioners and all Research personnel who are hired into an occupation requiring licensure, professional certification or registration..

f. Change in Status: Practitioners must agree to provide care to patients within the scope of their delineated Clinical Privileges, Collaborative Practice Agreement or Scopes of Practice and advise the Medical Center Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges or functions which are held. Advise the Medical Center Director through the Chief of Staff of any challenges or claims against professional credentials, professional competence or professional conduct and any felony criminal convictions or health issues that could affect professional performance as soon as possible, but no longer than 15 days of knowledge of such occurrences after notification of the practitioner. The practitioner applying for a change in appointment status, such as part-time to full time or contract to Federal employee, will be required to submit a new Supplemental Attestation via the VetPro electronic credentialing system.

### **Section 3.03 Code of Conduct**

1. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being on duty as scheduled. (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts. Reference RLR VAMC Medical Center Memorandum, Conflict of Interest.
2. Behavior or Behaviors That Undermine a Culture of Safety: VA recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. VA strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact.

Behavior or Behaviors That Undermine a Culture of Safety is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that behavior or behaviors that

undermine a culture of safety is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, behavior or behaviors that undermine a culture of safety may reach a threshold such that it constitutes grounds for further inquiry by the Medical Executive Committee into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action.

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

Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing behavior or behaviors that undermine a culture of safety on the part of other providers. VA urges its providers to support their hospital, practice, or other healthcare organization in their efforts to identify and manage behavior or behaviors that undermine a culture of safety, by taking a role in this process when appropriate. Reference RLR VAMC Medical Center Memorandum, Health Status and Impaired Professional Program.

3. Professional Misconduct: Behavior by a professional that creates the appearance of a violation of ethical standards or has compromised ethical standards will not be tolerated. Reference RLR VAMC Medical Center Memorandum, Integrated Ethics.

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

### **Section 4.01 Leaders**

1. Composition:
  - a. Chief of Staff
  - b. Assistant Chief of Staff
  - c. Clinical Service Chiefs
  - d. Secretary
  - e. Secretary-Elect
2. Selection:
  - a. Chief of Staff will be appointed by VA Central Office upon recommendation of the Medical Center Director in accord with VA policy and regulations.
  - b. Assistant Chief of Staff will be appointed with recommendation by the Chief of Staff and approved by the Medical Center Director.
  - c. Clinical Service Chiefs will be appointed with recommendation from VA Central Office by the Medical Center Director in accord with VA policy and regulations.
  - d. The Secretary, Secretary-elect shall be elected by the membership of the Medical Staff. The term of office for the Secretary and Secretary-elect shall be one year (October 1 to September 30) and the Secretary-elect shall succeed the Secretary. Qualifications for the Secretary and Secretary-elect include: completion of an approved residency, staff membership in a non-centralized position for at least one year, an appointment that is 5/8's or greater, regardless of method of remuneration, and active participation in patient care and



teaching program. At the time of election, the Secretary will not be eligible as a candidate for Secretary-elect.

- e. The annual election will take place at a Medical Staff meeting.
- f. A nominating committee will be appointed by the Secretary prior to the election, composed of at least three, 4/8's time or greater, members of the Medical Staff who hold non-centralized positions.
- g. The nominating committee will develop a slate of at least two candidates for the office of Secretary-elect. The slate of candidates will be submitted to the membership prior to the June meeting.
- h. This will not preclude nominations from the floor at the time of election nor by petition of members of the Medical Staff.
- i. The candidate with greatest number of votes will be elected.
- j. In the event of resignation, transfer, etc., of the Secretary or Secretary-elect, the nominating committee will develop a slate of candidates for the next staff meeting or the vacancy will be filled through a new election accomplished by a mail-out ballot. The Secretary-elect will succeed early to fill the unexpired term of the Secretary.

### 3. Removal of Officers

a. Officers of the Medical Staff will be accorded due process in removal proceedings. Actions to remove officers of the Medical Staff will be carried out in accordance with applicable VA Policy and Regulation.

b. Proposals to remove an officer of the Medical Staff will be processed concurrent with and in accordance with VA Policy as outlined in VA Manual Procedures as outlined in VA Handbook 5019/2, Part III and VA Handbook 5021 & VA Directive 5021.

c. Elected Officers - Upon petition to the Medical Center Director by 25% of the voting members of the Medical Staff, a recall election by secret ballot will be held within ten (10) days. Greater than two-thirds majority is necessary to remove such an elected officer. In the event of a sustained recall, the remainder of the elected officer's term will be completed by the Medical Staff member next scheduled to serve in that office. This event will not affect the subsequent term for which the officer was elected.

d. Questions should be referred to the VHA Office of Quality, Safety & Value; the Office of Human Resources Management, VACO; or the Office of Regional Counsel.

### 4. Responsibility

a. Medical Staff members should become knowledgeable of this process and applicable VA Policy and regulations as related to membership and removal of elected officers.

b. Medical Staff members are responsible for adhering to this process in considering or recommending removal of any officer.

c. The Medical Center Director is responsible for appropriate coordination and actions when considering or processing a proposed removal of a medical staff officer.

### 5. Duties:

- 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 all matters of mutual concern within the medical center;

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

(3) Serve as Chair of the Executive Committee of the Medical Staff;

(4) Be responsible for the enforcement of Medical Staff Bylaws, rules and regulations, in collaboration with the chiefs of the clinical services;

(5) 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 Executive Committee of the Medical Staff;

(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 through the Associate Chief of Staff for Research and Chief Education Officer for the research and educational activities of the Medical Staff, and

(9) Be spokesperson for the Medical Staff in its external, professional and public relations.

b. The Secretary of the Medical Staff shall:

(1) serve as a member of the ECMS/Professional Standards Board;

(2) serve as Vice-Chair of the Executive Committee of the Medical Staff;

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

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

c. The Secretary-elect of the Medical Staff shall:

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

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

(3) serve as a member-at-large of the Executive Committee of the Medical Staff.

## **Section 4.02 Leadership**

1. The Organized Medical Staff, through its committees and Service Chiefs, provides counsel and assistance to the Chief of Staff and Director regarding all facets of patient care, treatment, and services including evaluating and improving the quality and safety of patient care services. The administrative organization of the medical staff shall follow VA regulations.

## Section 4.03 Clinical Services

### 1. Characteristics:

- a. Clinical Services are organized to provide clinical care and treatment under leadership of a Service Chief.
- b. Clinical Services hold service-level meetings at least at least quarterly.

### 1. Functions:

- a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety, (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients; patient satisfaction activities; patient safety and risk management activities; and utilization management.
- b. Provides referral, transfer or discharge of patients to another level of care, health professional or setting, based on the patient's assessed needs and the hospital's capacity to provide the care.
- c. Assist in identification of important aspects of care for the Service, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities.
- d. Maintain records of meetings that include reports of conclusions, data, recommendations, responsible person, actions taken, and an evaluation of effectiveness of actions taken.
- e. Develop criteria for recommending clinical privileges for members of the Service and ensure that ongoing professional practice evaluation is continuously performed and results are utilized at the time of re-privileging.
- f. Define and/or develop clinical privilege statements including levels (or categories) of care that include all requirements of VHA Handbook 1100.19.
- g. Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within the Service.
- h. Annually review privilege templates for each Service/Section to determine whether sufficient space, equipment, staffing, and financial resources are in place, or available within a specified time frame, to support the privilege delineation and make recommendations to the Executive Committee of the Medical Staff.
- i. Each of the clinical Services shall conduct meetings at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by medical staff and responsible party of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.

### 2. Selection and Appointment of Service Chiefs: Service Chiefs are appointed by the Medical Center Director based upon the recommendation of the Chief of Staff and Affiliation Partnership Council. Service Chiefs must hold certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

### 3. Duties and Responsibilities of Service Chiefs: The Service Chief is administratively responsible for the operation of the Service and its clinical and research efforts, as appropriate. In addition to duties listed below, the Service Chief is responsible for assuring the Service performs according to applicable VHA performance standards. These requirements are described in individual Performance Plans for each Service Chief. Service Chiefs are responsible and accountable for:

- a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as Service Chief.
- b. Clinically related activities of the Service.
- c. Administratively related activities of the department, unless otherwise provided by the organization.
- d. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges. Reference Medical Center Memorandum, Professional Practice Evaluation.
- e. Assuring that individuals with clinical privileges provide service within the scope of privileges granted.
- f. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service.
- g. Recommending clinical privileges for each member of the Service.
- h. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the Service and communicating the recommendations to the relevant organizational authority.
- i. The integration of the Service into the primary functions of the organization.
- j. The coordination and integration of interdepartmental and intradepartmental services.
- k. The development and implementation of policies, Medical Center Memorandum, and procedures that guide and support the provision of care, treatment, and services.
- l. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.
- m. The determination of the qualifications and competence of service personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services.
- n. The continuous assessment and improvement of the quality of care, treatment, and services.
- o. The maintenance of and contribution to quality control programs, as appropriate.
- p. The orientation and continuing education of all persons in the service.
- q. The assurance of space and other resources necessary for the service defined to be provided for the patients served.
- r. 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 V. MEDICAL STAFF COMMITTEES**

### **Section 5.01 General**

1. Committees are either standing or special.
2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.
3. The presence of 25% of a committee's members will constitute a quorum.

4. Membership – Recommendation for committee membership may come from the committee itself to the Chief of Staff and Secretary of the Medical Staff. The Secretary of the Medical Staff will advise and consent to the appointment of committee members to all standing, special and multidisciplinary Medical Staff committees with the exception of the Executive Committee of the Medical Staff. Establishment of new Medical Staff committees will be presented to the Executive Committee of the Medical Staff for recommendation to the Medical Center Director for approval.
5. Recommendation to remove a member of a committee may be proposed to the Chairman, accepted by the majority of members of that committee and removal concurred by the Chief of Staff and Medical Center Director.
6. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff.

### **Section 5.02 Executive Committee of the Medical Staff (ECMS)**

1. Membership: Incumbents of the following positions will serve as members of the Executive Committee of the Medical Staff. This membership may be expanded as needed by a majority vote of the Committee and the concurrence of the Chief of Staff and Medical Center Director.

Chief of Staff	Chair, Voting Member
Associate Chief of Staff Chief, Ambulatory Care Service	Voting Member
Associate Chief of Staff for Research	Voting Member
Associate Director for Patient Care Services	Voting Member on issues related to nursing patient care services and nurse credentialing
Assistant Chief of Staff	Voting Member
Chief, Anesthesia Service	Voting Member
Chief, Compensation & Pension Service	Voting Member
Chief, Dental Service	Voting Member
Chief, Division of General Internal Medicine	Voting Member
Chief, Medicine Service	Voting Member
Chief, Neurology Service	Voting Member
Chief, Pathology/Laboratory Medicine Service	Voting Member
Chief, Physical and Rehabilitation Medicine	Voting Member
Chief, Psychiatry & Mental Health Service	Voting Member
Chief, Radiology Service	Voting Member
Chief, Radiation/Oncology Service	Voting Member
Chief, Surgery Service	Voting Member
Emergency Department Director	Voting Member
Medical Staff Secretary	Voting Member
Medical Staff Secretary-Elect	Voting Member
Hospital Quality Manager	Non-Voting Member

Medical Center Director or Designee	Approving Official
Chief Education Officer	Non-Voting Member
Regional Counsel or Designee	Non-Voting Member
Chief, Pharmacy Service	Non-Voting Member
Advanced Practice Nurse *	

\*Advanced Practice Nurse (APN) representatives will be recommended from the Advanced Practice Committee in the Medical Center.

One APN will serve as a Non-Voting Member At-large at ECMS meetings. A second APN will serve as a Voting Member on the Executive Committee of the Medical Staff/Professional Standards Board who attends and votes on matters related to APN Clinical Function Collaborative Practice Agreements.

## 2. Functions of the Executive Committee of the Medical Staff

- a. Acts on behalf of the Medical Staff between Medical Staff meetings.
- b. Voting members maintain process for reviewing credentials and delineation of clinical privileges and/or collaborative agreements to ensure authenticity and appropriateness of the process in support of clinical privileges and/or collaborative agreements requested; to address the scope and quality of services provided within the facility.
- c. Acts to ensure effective communications between the Medical Staff and the Director.
- d. The ECMS will ensure that reviews of functional areas listed below are accomplished, meeting all steps of the Quality Management process or other applicable standards. These reviews will be used in monitoring the quality and appropriateness of patient care delivered. The Office of Quality Management will provide staff support to the ECMS in accomplishing this responsibility. Service Chiefs, Committee Chairpersons, and other responsible individuals will assure that all performance improvement activity is adequately and timely documented in meeting minutes.

The ECMS has oversight over, but not limited to, the following functional areas:

- Autopsy Review
- Blood Usage Review Committee
- Cancer Committee
- Contracted Clinical Services
- Critical Care Committee
- Infection Control Committee
- Medical Records Review
- Medical & Radiological Invasive Procedure Review
- Pharmacy, Therapeutics & Nutrition Committee
- Radionuclide Safety Committee
- Research and Development Committee
- Resident Supervision
- Reusable Medical Equipment Committee
- Risk Management
- Operative/Other Invasive and Non-Invasive Procedures Review
- Utilization Review
- Peer Review for Quality Management

- e. Makes recommendations directly to the Medical Center Director regarding the:
  - (1) Organization, membership, structure and function of Medical Staff

- (2) Process used to review credentials and to delineate clinical privileges
  - (3) Individuals for Medical Staff membership
  - (4) Delineated clinical privileges, including Admitting privileges, for each eligible practitioner and clinical functions for Advanced Practice Nurses and Physician Assistants
  - (5) Organization of performance improvement activities of Medical Staff as well as mechanism used to conduct, evaluate, and revise such activities
  - (6) Process by which membership on Medical Staff may be terminated, consistent with applicable laws and VA regulations.
  - (7) Process for fair-hearing procedures, consistent with applicable laws and VA regulations.
- f. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.
  - g. Voting members oversee processes in place for instances of “for-cause” concerning a medical staff member’s competency to perform requested privileges.
  - h. Voting members oversee the process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.
  - i. Voting members oversee the process for fair-hearing procedures consistent applicable laws and VA regulations.
  - j. Voting members monitor medical staff ethics and self-governance actions.
  - k. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care through the Clinical/Performance Board.
  - l. Receives and acts on reports and recommendations from medical staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body.
  - m. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.
  - n. Acts as and carries out the function of the Medical Staff Professional Standards Board by its voting members, which includes review and recommendation of medical staff appointment, delineation of clinical privileges and collaborative practice agreements for Advanced Practice Nurses and Physician Assistants. Reviews and makes recommendation regarding disciplinary and adverse actions to the Medical Center Director.
  - o. Provides oversight and guidance for fee basis/contractual services.
  - p. Annually reviews and makes recommendations for approval of the Service-specific privilege lists and ongoing professional performance evaluation criteria.
  - q. Voting physician members act as and carry out the function of the Physical Standards Board, Reference RLR VAMC Medical Center Memorandum, which include:
    - (1) The evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician.
    - (2) Determine whether VHA personnel are physically and/or mentally suitable for appointment or retention in VA employment.

(3) The Employee Health Physician may perform physical examinations. All examinations of a questionable nature not resolved by appropriate consultation will be referred to the Physical Standards Boards.

### 3. Meetings:

a. Regular Meetings: Regular meetings of the Executive Committee of the Medical Staff (ECMS) shall be held at least ten times per year. The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chairpersons of the various committees of the Medical Staff shall attend regular meetings of the Executive Committee of the Medical Staff, when necessary, to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the Executive Committee of the Medical Staff.

b. Emergency Meetings: Emergency meetings of the Executive Committee of the Medical Staff may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the Executive Committee of the Medical Staff, the Director as the Governing Body, Acting Chief of Staff or Secretary of the Medical Staff, may call an emergency meeting of the Committee.

c. Meeting Notice: All Executive Committee of the Medical Staff members shall be provided advanced notice, written or e-mail, of the time, date, and place of each regular meeting and reasonable notice of each emergency meeting.

d. Agenda: The Chief of Staff, or in his absence, the Acting Chief of Staff or Secretary to the Medical Staff shall Chair the Executive Committee of the Medical Staff. The Chair shall establish the agenda for all meetings, and a written or electronic agenda shall be prepared and distributed prior to committee meetings.

e. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the Executive Committee of the Medical Staff shall be 25% of the voting members of the committee. Action may be taken by majority vote at any meeting or via electronic vote by members. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

f. Minutes: Written minutes shall be made and kept on all meetings of the Executive Committee of the Medical Staff, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff.

g. Communication of Action: The member or representative proposing a recommendation or action at a meeting of the Executive Committee of the Medical Staff is responsible for communicating such action to any person who is directly affected by it.

### 4. Conflict Management:

a. When the ECMS prepares to adopt a new rule or regulation, or a revision or deletion to an existing rule or regulation of the Medical Staff, these proposals will be forwarded to the voting



members first for their review and comment before submitting a final recommendation to the Medical Center Director.

b. Medical Staff members are notified via e-mail of changes in policy or regulation.

c. Medical Staff members may voice their concerns with proposed or completed actions of the ECMS to the Secretary of the Medical Staff, Chief of their clinical Service or Chief of Staff. These suggestions or concerns will be brought to the ECMS for review and discussion. At the discretion of the Chief of Staff, the member or members may be invited to the ECMS to express their views or concerns in person.

d. If there is conflict between the Medical Staff and leadership groups of the Medical Center, the Medical Center leadership facilitates management of the conflict through Human Resource representatives or others who have the required skills and expertise for such facilitation.

### **Section 5.03 Committees of the Medical Staff**

1. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds (d) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners and (e) for such additional purposes as may be set forth in the charges to each committee.
2. Medical Staff Committees include but are not limited to the following. Additional committees along with local policies, rules and regulations are outlined and defined in RLR VAMC Medical Center Memorandums and service level policy:
  - a. Operative/Other Invasive and Non-OR Invasive procedures review is performed at least quarterly by those departments/ services performing surgical and non-invasive procedures or by a Medical Staff committee to help assure that surgery and non-OR invasive procedures performed in the hospital are justified and of high quality. The review process is outlined in RLR VAMC Medical Center Memorandum.
  - b. Drug Usage Evaluation is performed by the Medical Staff as a criteria-based, ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to help assure that they are provided appropriately, safely, and effectively. Activities are guided by the Pharmacy, Nutrition and Therapeutics Committee as outlined in RLR VAMC Medical Center Memorandum.
  - c. Pharmacy and Therapeutics function is performed by the Medical Staff, in cooperation with Pharmacy Service, Patient Care Services, other management and administrative services. Refer to RLR VAMC Medical Center Memorandum and VISN Policy.
  - d. Medical Record Review at the point of care are performed at or after the point of care for elements determined at the discretion of the Medical Staff and Medical Center leadership with the defined elements being reviewed no less than annually.
  - e. Blood Usage Review is performed by the Transfusion Review Committee, Reference RLR VAMC Medical Center Memorandum.

f. The Medical Staff participates in other review functions including internal and external disaster plans.

g. The Medical Staff actively participates, as appropriate, in the following Risk Management and Patient Safety activities related to the clinical aspects of patient care:

(1) The identification of general areas of potential risk in the clinical aspects of patient care and safety;

(2) The development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety, and evaluation of these cases;

(3) The correction of problems in the clinical aspects of patient care and safety identified by risk management activities; and

(4) The design of programs to reduce risk in the clinical aspects of patient care and safety.

(5) Provision for special procedures with intent of minimizing risk to patients such as, but not limited to, use of restraints, seclusion, moderate sedation.

h. The effectiveness of all functions – the monitoring and evaluation of the quality and appropriateness of patient care provided by all individuals with clinical privileges/clinical functions, invasive and non-invasive procedures, drug usage evaluation, the medical record review function, blood use review, the pharmacy, nutrition and therapeutics functions, and other review functions – is evaluated as part of the annual reappraisal of the medical center's performance improvement program.

Information Flow to Executive Committee of the Medical Staff: All Medical Staff Committees, including but not limited to those listed above, will submit minutes of all meetings to the Executive Committee of the Medical Staff on a quarterly basis after the minutes are approved and will submit such other reports and documents as required and/or requested by the Executive Committee of the Medical Staff.

#### **Section 5.04 Committee Records and Minutes**

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

#### **Section 5.05 Establishment of Committees**

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

## **ARTICLE VI. MEDICAL STAFF MEETINGS**

1. Regular Meetings: Regular meetings of the Medical Staff as a whole shall be held at least annually. A record of attendance shall be kept.
2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the Executive Committee of the Medical Staff. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting will be given in writing or via electronic message to the Medical Staff. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Director in writing or via electronic message and stating the reason(s) for the request.
3. Quorum: For purposes of Medical Staff business, twenty-five (25) percent of the Active medical staff membership constitutes a quorum. Absentee ballots may be counted to approve policies such as changes in Bylaws, Rules and Regulations.
4. Meeting Attendance: Members of the Active Medical Staff (5/8ths time or greater) are expected to attend regular Medical Staff meetings and Service-level meetings. Excused absences should be documented.

## **ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING**

### **Section 7.01 General Provisions**

1. Independent Entity: The Roudebush VA Medical Center is an independent entity, granting privileges to the medical staff through the Executive Committee of the Medical Staff and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Advanced Practice Nurses and Physician Assistants must practice under a scope of practice or collaborative practice agreement.
2. Credentials Review: All Licensed Independent Practitioners (LIP), Advanced Practice Nurses and Physician Assistants who hold clinical privileges, collaborative practice agreements or scopes of practice will be subjected to full credentials review at the time of initial appointment, at the time of reappraisal (not greater than a 2 year period), and after a break in service. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners applying for a change in appointment status, such as part-time to full time or contract to Federal Employee, will be required to submit a new VetPro Supplemental Questionnaire, reporting full details of any positive response given.
3. Deployment/Activation Status:
  - a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be placed in a "Deployment/Activation Status" and the credentialing file will remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Practitioner will update the credentialing file to current status.
  - b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the Executive Committee of the Medical Staff for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.

- c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.
  - d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care.
- 4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:
  - a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.
  - b. Federal law authorizing VA to contract for health care services.
- 5. Initial Focused Professional Practice Evaluation:
  - a. The initial focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This occurs with a new Practitioner or an existing Practitioner who requests a new privilege. The performance monitoring process is outlined in RLR VAMC Medical Center Memorandum, Professional Practice Evaluation.
  - b. The FPPE is separate and distinct from the Human Resource probationary review.
    - (1) Initial and certain other appointments made under 38 U.S.C. 7401(l), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations. If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period.
  - c. Successful completion of the FPPE does not equate to successful completion of a probationary period.
- 6. Ongoing Professional Practice Evaluation:
  - a. The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Reference RLV VAMC Medical Center Memorandum, Professional Practice Evaluation.
  - b. In considering the reappointment of staff who have not practiced at this facility in the past two years and pursuant to the requirement that practitioner specific performance improvement data be reviewed as part of the credentialing process, a practitioner may be reappointed based on a peer recommendation from the individual's supervisor (i.e., Chairman, Service/Department Head) from the institution where the individual actively practices in order to support the request for clinical privileges and medical staff membership. The acceptability of such external data shall be at the discretion of the Executive Committee of the Medical Staff. It is anticipated that the substitution of external data will apply only to those individuals who conduct the greater majority of their practice outside of the Medical Center.

- c. In those instances where a practitioner does not meet established criteria, the service chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.
- d. The Executive Committee of the Medical Staff/Professional Standards Board must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.
- e. The Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

## **Section 7.02 Application Procedures**

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete application. Any time gaps in professional history greater than 30 days must be accounted for.
  - a. VetPro Required: All healthcare providers must submit credentialing information into VHA's electronic credentialing system, VetPro, as required by VHA policy to include the following:
    - (1) Licensure: All licenses current and inactive ever held by applicant and the status of each.
    - (2) Sanctions or Limitations: 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 or involuntarily surrendered, or not renewed.
    - (3) U.S. Citizenship: Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, Practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment with proof of current visa status and Immigration and Naturalization Service documentation regarding employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.
    - (4) References: The names and addresses of a minimum of four (4) 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 are required. 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. Recommending and approving officials may require additional information.
    - (5) Previous Employment: A list of all health care institutions or other organizations where the Practitioner is/has been appointed, utilized or employed (held a professional appointment), including:
      - i) Name of health care institution or practice.
      - ii) Term of appointment or employment and reason for departure. Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary surrender.

(6) DEA/CDS Registration: A description of:

i) Status, either current or inactive.

ii) Any previously successful or currently pending challenges to, voluntary or involuntary relinquishment of, the Practitioner's DEA/CDS registration.

(7) Liability Claims History: Status and details regarding all claims (Open, Pending, Closed, Dismissed, etc.) made against the Practitioner in the practice of any health occupation including final judgments or settlements.

(8) Loss of Privileges: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

(9) Pending Challenges: Pending challenges against the Practitioner by any hospital, licensing agency, professional group, or society.

b. Completion of VHA or RLR VAMC forms to meet the following requirements:

(1) Release of Information: Authorization for release of information, written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, competence, health status, disciplinary or adverse actions taken or pending, professional conduct, malpractice claims from any past or present affiliate, institution, government or non-government entity.

(2) Declaration of Health: Signed declaration of health status consistent with physical and mental capability to satisfactorily perform the duties of the Medical Staff assignment within approved clinical privileges.

(3) Agreement: Signed agreement to abide by the Medical Staff Bylaws, Rules, Regulations and Policies, and to provide continuous care to patients at the Roudebush VA Medical Center.

(4) Delineation of Clinical Privileges: Completion of RLR VAMC approved privilege delineation template for the specific Service and/or specialty for which the applicant is competent and recommended by the appropriate Service Chief.

i. Privileges requested to perform a new technique or procedure not previously performed at the RLR VA Medical Center or not included on a Service's delineation of clinical privilege form must be requested following requirements outlined in MCM, "Approval for New Procedures, Techniques or Treatment Modalities to be Performed at the Roudebush VA Medical Center".

ii. Privileges granted to an applicant, including contracted practitioners, are based not only on the applicant's qualifications, but also on consideration of the procedures and types of care or services that can be performed or provided within the RLR VA Medical Center. Privileges will only be granted if the hospital has adequate facilities including equipment, number, types and qualifications of support personnel and any necessary support services. Privileges are not denied based on inter-service competition for patients referred or otherwise, when all practitioners applying have adequately demonstrated training and skills.

(5) Identification: Provide a government photograph identification to be verified as the individual applying for appointment/clinical privileges.

2. Primary Source Verification: In accordance with VHA Handbook 1100.19 Credentialing and Privileging and VA Handbook 5005, Part II, Chapter 3 the facility will obtain primary source verification of:
  - a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described above, item 1a(4).
  - b. Verification of current or most recent clinical privileges held, if available.
  - c. Verification of status of all licenses current and previously held by the applicant.
  - d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.
  - e. Verification of board certification, if applicable.
  - f. Verification of education credentials used to qualify for appointment including all postgraduate training.
  - g. Evidence of registration with the National Practitioner Data Bank (NPDB) Proactive Disclosure Service and the Healthcare Integrity and Protection Data Bank, for all members of the Medical Staff, Advanced Practice Nurses and Physician Assistants.
  - h. For all physicians, screening will be obtained through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner will be obtained.
  - i. Confirmation of health status documented by the current or most recent supervisor for new appointments or the RLR VAMC Employee Health Physician. For reappointment, the Clinical Service Chief confirms health status.
  - j. Evidence and verification of the status of any alleged or confirmed malpractice.
  - k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the RLR VA Medical Center Medical Staff Bylaws, Rules, and Regulations.
3. The applicant's attestation to the accuracy and completeness of the information submitted. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the Practitioner says the information provided is factually incorrect.
4. Burden of Proof: The applicant has the burden of obtaining and producing all needed information for a proper evaluation of the applicant's professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of the request to the applicant may serve as a basis for denial of employment consideration.

### **Section 7.03 Process and Terms of Appointment**

1. Chief of Service Recommendation: The Chief of the Service or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met.

- a. Individuals with clinical privileges are assigned to and have clinical privileges in one clinical service/department, but may be granted clinical privileges in other services.
  - b. Exercise of clinical privileges within any department/service is subject to the rules and regulations of the service/department and to the authority of the service chief/department head.
2. CMO Review: In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be submitted to the VISN Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the Executive Committee of the Medical Staff if the response from the NPDB-HIPDB query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of \$550,000 or more, or (c) two medical malpractice payments totaling \$1,000,000 or more. The higher level review by the VISN CMO is 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 Chief's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.
3. Voting members of the Executive Committee of the Medical Staff/Professional Standards Board recommend Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
4. Director Action: Recommended appointments to the Medical Staff should be acted upon by the Director within 30 work days of receipt of a fully complete application, including all required verifications, references and recommendations from the appropriate Service Chief and Executive Committee of the Medical Staff/Professional Standards Board.
5. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or notice of inability to consider application because of inadequate information.

#### **Section 7.04 Credentials Evaluation and Maintenance**

1. Evaluation of Competence: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including performance monitors) that the Practitioner applying for clinical privileges or clinical functions has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges or clinical functions requested.
2. Good Faith Effort to Verify Credentials: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The applicant should assist in providing required information for this documentation. Verification of licensure or required certification is excluded from good faith effort in lieu of primary source verification.
3. Maintenance of Files: A complete and current Credentialing and Privileging (C&P) file including the electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C&P file is the responsibility of the Chief of Staff. Any time a file is found to lack required documentation, without an entry as noted above in



paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain the documentation.

4. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges or clinical functions, at the time of request for additional privileges/functions (as determined by Executive Committee of the Medical Staff), or in case of a "for-cause" event requiring a focused review. Reference RLR VAMC MCM, Professional Practice Evaluation.

## **ARTICLE VIII CLINICAL PRIVILEGES**

### **Section 8.01 General Provisions**

1. Clinical privileges and clinical functions for Advanced Practice Nurses and Physician Assistants are granted for a period of no more than 2 years.
2. Reappraisal of privileges is required of each Medical Staff member and for clinical functions of Advanced Practice Nurses and Physician Assistants. Reappraisal is initiated by the Credentialing Service with renewal packet sent to individual Practitioners prior to expiration date.
3. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.
4. For initial/ reappointment and renewal, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Executive Committee of the Medical Staff/Professional Standards Board. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges. (Reference VHA Credentialing & Privileging Handbook 1100.19.)
5. Privileges requested to perform a new technique or procedure not previously performed at the RVAMC or not included on a Service's delineation of clinical privilege form must be requested following requirements outlined in Medical Center Memorandum, Approval for New Procedures, Techniques, or Treatment Modalities to be Performed at the Roudebush VA Medical Center (RVAMC).
6. Requirements and processes for requesting and granting privileges are the same for all Practitioners who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
7. Delineation of an individual's clinical privileges will reflect the limitations, if any, on the individual's clinical privileges to admit and treat patients and/or direct the course of treatment for the conditions for which the patients are admitted.
8. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.
9. Teleconsultation: All Practitioners providing teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

## **Section 8.02 Process and Requirements for Requesting Clinical Privileges**

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.
2. Requests in Writing: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.
3. Credentialing Application: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
  - a. Complete appointment information as outlined in Section 7.02.
  - b. Application for clinical privileges as outlined in this Article.
  - c. Evidence of professional training and experience in support of privileges requested. Recommending and approving officials may require additional information or documentation.
  - d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. Confirmation of health status documented by the current or most recent supervisor for new appointments or the RLR VAMC Employee Health Physician. Reasonable evidence of health status may be required by the Executive Committee of the Medical Staff.
  - e. A statement of the current status of all licenses and certifications held.
  - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of knowledge of the adverse action.
  - g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.
  - h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.
5. Basic Life Support (BLS) Certification: All clinically active staff involved in direct patient care must maintain current BLS certification.
6. Advanced Cardiac Life Support (ACLS): Certification is required for Emergency Department physicians, staff who perform moderate sedation, and for those code team members charged with running a Code Blue.
7. Moderate Sedation: To qualify for moderate sedation Practitioner must have specific, approved clinical privileges including successful completion of written test and current ACLS certification. Practitioners must adhere to the guidelines outlined in the RLR Medical Center Memorandum, Moderate Sedation.

8. Airway Management: Airway management is restricted to practitioners who have specific approved clinical privileges. Reference RLR Medical Center Memorandum, Out-of-Operating Room Airway Management.

### **Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges**

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:
  - a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic re-credentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.
  - b. Supporting documentation of professional training and/or experience not previously submitted.
  - c. Reasonable evidence of current ability to perform clinical privileges as requested by appropriate Service Chief, Executive Committee of the Medical Staff/Professional Standards Board or the Chief of Staff.
  - d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by the current supervising physician, Service or Section Chief.
  - e. Reappraisal requires completion of Continuing Medical Education programs accredited by a recognized authority acceptable to the Executive Committee of the Medical Staff/hospital and/or participation in hospital sponsored educational activities are considered in the reappraisal/renewal process. Completion of sufficient continuing medical education of a minimum of 25 Continuing Education Credits annually is required for reappointment or renewal. CECs may consist of formal educational programs attended, programs provided, relevant readings, etc., but must be documented by the practitioner. At the time of reappointment/renewal the practitioner will sign an attestation to the completion of the required 25 hours per year of continuing education credits. The practitioner will be responsible for providing actual documentation of continuing education credits if requested by the Executive Committee of the Medical Staff. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.
  - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of knowledge or notification of the adverse action.
  - g. Names and addresses of two peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
  - h. Names of other hospitals or facility at which privileges are held and requests for copies of current privileges held.
2. Verification: Before granting subsequent clinical privileges, the Credentialing Office will ensure that the following information is on file and verified with primary sources, as applicable:

- a. Current and previously held licenses in all states.
- b. Current and previously held DEA/State CDS registration.
- c. NPDB-HIPDB PDS Registration.
- d. FSMB query (physicians only)
- e. Physical and mental health status information from applicant.
- f. Physical and mental health status confirmation.
- g. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and focused professional practice evaluation.
- h. Applicant's attestation of continuing education credits for renewal.
- i. Documentation of any required competencies for specific privileges requested as per Service clinical privileging criteria.
- j. Final disposition of any malpractice claims.
- k. Additional training or education claimed by the applicant.
- l. Board certifications, if applicable.

#### **Section 8.04 Processing an Increase or Modification of Privileges**

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Chief.
2. Privileges requested to perform a new technique or procedure not previously performed at the RLR VAMC or not included on a Service's delineation of clinical privilege form must be requested following requirements outlined in Medical Center Memorandum, Approval for New Procedures, Techniques, or Treatment Modalities to be Performed at the Roudebush VA Medical Center (RVAMC).
3. Primary source verification is conducted if applicable, e.g. provider attests to additional training or experience.
4. Current NPDB-HIPDB PDS Registration prior to rendering a decision.
5. Verification of status of current licensure.
6. A modification or enhancement of, or addition to, existing clinical privileges requires the recommendation of the appropriate clinical Service Chief, the Executive Committee of the Medical Staff/Professional Standards Board and approval by the Medical Center Director.

#### **Section 8.05 Recommendations and Approval for Initial/Renewal, of Clinical Privileges**

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.
2. The Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.
  - a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:

- i) Medical/Clinical knowledge (education competency).
  - ii) Interpersonal and Communication skills (documentation; patient satisfaction).
  - iii) Professionalism (personal qualities).
  - iv) Patient Care (clinical competency).
  - v) Practice-based Learning & Improvement (research and development).
  - vi) System-based Practice (access to care).
- b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring and evaluation activities such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and other Ongoing Professional Performance Evaluations.
3. The Executive Committee of the Medical Staff/Professional Standards Board recommends granting clinical privileges to the Medical Center Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws.
  4. The effective date of clinical privileges can be the date signed by the Director, but may not become effective at a date later than 30 calendar days from the date signed by the Director.
  5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A copy of approved clinical privileges are sent to the Practitioner. Clinical privileges will be available to hospital staff on a need-to-know basis and Service Chief's offices via a network computerized data base in order to ensure practitioners are functioning within the scope of the approved clinical privileges. Practitioners performing procedures outside the scope of their approved clinical privileges may be subject to disciplinary or administrative action.
  6. Clinical functions/collaborative practice agreement applications for Advanced Practice Nurses and Physician Assistants follow the Medical Staff process.

### **Section 8.06 Exceptions**

1. Temporary Privileges for Urgent Patient Care Needs: Temporary clinical privileges for urgent patient care needs may be granted at the time of an initial appointment for a limited period of time (not to exceed 60 calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff. Temporary privileges are not an alternative to the routine credentialing and privileging process.
  - a. A completed application must be submitted by the applicant for temporary privileges as outlined in Section 2 of Article VII.
  - b. Temporary privileges are based on verification of the following:
    - (1) One, active, current, unrestricted license with no previous or pending actions.
    - (2) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.
    - (3) Verification of current comparable clinical privileges at another institution (if applicable).
    - (4) Response from NPDB-HIPDB PDS registration with no match.

- (5) Response from FSMB with no reports (physicians only).
  - (6) No current or previously successful challenges to licensure.
  - (7) No history of involuntary termination of medical staff membership at another organization.
  - (8) No voluntary or involuntary limitation, reduction, denial, or loss of clinical privileges.
  - (9) No final judgment adverse to the applicant in a professional liability action.
2. Emergency Care: Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.
  3. Disaster Privileges: Emergency credentialing and privileging during a declared disaster may be granted during the duration of the emergency situation by the Chief of Staff or their designee as outlined in the RLR VAMC Emergency Disaster Plan.
  4. Inactivation of Privileges: The inactivation of privileges occurs when a Practitioner is not an actively practicing member of the medical staff for an extended period of time such as extended sick leave or sabbatical with or without clinical practice while on sabbatical.
    - a. When the Practitioner returns to the Facility, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be verified again. Inactivation of privileges may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.
    - b. At the time of inactivation of privileges, including separation from the medical staff, the Medical Center Director ensures that within 7 calendar days of the date of separation, information is received suggesting that Practitioner met generally accepted standards of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.
  5. Deployment and Activation Privilege Status: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process for returning privileges to an active status is communicated to the Practitioner before deployment, as outlined in VHA Credentialing and Privileging Handbook 1100.19. <NOTE: No step in the process should be a barrier in preventing the Practitioner from returning to the Facility in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.>

## **ARTICLE IX INVESTIGATION AND ACTION**

1. Request for Investigation: Whenever the behaviors, activities and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Facility Director. All requests for investigation must be made in writing or via electronic message to the Chief of Staff supported by reference to specific activities or conduct, which constitute the

grounds for the request. The Chief of Staff promptly notifies the Director in writing or via electronic message of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. NOTE: If the person under review, is an employee then the processes must also follow VA Directive 5021 - Management of Employees.

2. Fact Finding Process: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article IX, a fact finding process will be implemented. This fact-finding process should be completed within 30 days or there needs to be documentation as to why that was not possible. The Chief of Staff may form ad hoc investigation committee for this fact-finding process. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities and/or professional conduct of the Practitioner are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, the Chief of Staff may propose a summary suspension of privileges to the Medical Center Director. If the Medical Center Director agrees with the summary suspension of privileges, a review by the Executive Committee of the Medical Staff/Professional Standards Board will be conducted. Written notice of the summary suspension must be delivered in person or via certified mail outlining the specific reason(s) for the suspension and offer the Practitioner with an opportunity to provide any information regarding the concerns presented within 14 calendar days from the receipt of such notice to the Chief of Staff.
3. Review by the Executive Committee of the Medical Staff/Professional Standards Board (ECMS/PSB): Within 30 calendar days of the summary suspension, ECMS/PSB members must review the information presented from the fact finding process, including any response from the Practitioner, and make a recommendation to the Medical Center Director. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. A record of such proceeding is made by the ECMS/PSB.
  - a. The ECMS/PSB may reject or modify the recommendations; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommend that the Practitioner's staff membership be suspended or revoked.
  - b. Any recommendation by the ECMS/PSB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.
  - c. Reduction of privileges may include, but not be limited to, functioning under supervision<sup>1</sup>, restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration

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<sup>1</sup> See the definition of Proctoring for an explanation of the difference between proctoring and supervision.

contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.

- d. Revocation of privileges refers to the permanent loss of clinical privileges.
- 4. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, all or a portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by Facility Director. The process shall follow VHA Handbook, Credentialing and Privileging 1100.19.
- 5. Automatic Suspension of Privileges: Privileges may be automatically suspended for administrative reasons which may occur in instances where the provider is behind in dictation, or allowed a license to lapse and therefore does not have an active, current, unrestricted license. Such instances must be weighed against the potential for substandard care, professional misconduct or professional incompetence. A thorough review of the circumstances must be documented with a determination of whether the cause for the automatic suspension does or does not meet the test of substandard care, professional misconduct or professional incompetence. The process follows VHA Handbook, Credentialing and Privileging 1100.19.
  - a. If there are more than three automatic suspensions of privileges in one calendar year, or more than 20 days of automatic suspension in one calendar year, a thorough assessment of the need for the Practitioner's services must be performed and documented and appropriate action taken. Any action is to be reviewed against all reporting requirements, per VA regulation.
- 6. Actions Not Constituting Corrective Action: The Executive Committee of the Medical Staff/Professional Standards Board will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:
  - a. The appointment of an ad hoc investigation committee;
  - b. The conduct of an investigation into any matter;
  - c. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview or conference before the ECMS/PSB, any ad hoc investigating committee, the Chief of Staff, or any other committee or sub-committee with appropriate jurisdiction in connection with any investigation prior to a proposed adverse recommendation or action;
  - d. The failure to obtain or maintain any other mandatory requirement for Medical Staff membership;
  - e. The imposition of proctoring or observation on a Medical Staff member which does not restrict clinical privileges or the delivery of professional services to patients;
  - f. The issuance of a letter of warning, admonition, or reprimand;
  - g. Corrective counseling;
  - h. A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education; or
  - i. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.



## ARTICLE X FAIR HEARING AND APPELLATE REVIEW

- Denial of Medical Staff Appointment: When review of credentials and recommendations contained in a complete application result in denial of appointment, the appropriate approving authority will notify the applicant that appointment has not been recommended and briefly state the basis for the action.
  - Reduction of Privileges: Reference VHA Credentialing & Privileging Handbook 1100.19
  - Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:
    - i) A description of the reason(s) for the change.
    - ii) A statement of the Practitioner's right to be represented by counsel or a representative of the individual's choice, throughout the proceedings.
  - The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff's written notice of intent. The Practitioner must submit a response within 10 workdays of the Chief of Staff's written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed 10 additional workdays except in extraordinary circumstances.
  - Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the Practitioner disagrees with the Director's decision, a hearing may be requested. The Practitioner must submit the request for a hearing within five (5) workdays after receipt of decision of the Director.
2. Convening a Panel: The facility Director must appoint a review panel of three unbiased professionals, within 5 workdays after receipt of the Practitioner's request for hearing. These three professions will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:
- a. The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.
  - b. During such hearing, the Practitioner has the right to:
    - i. Be present throughout the evidentiary proceedings.
    - ii. Be represented by an attorney or other representative of the Practitioner's choice.  
**NOTE:** *If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses.*
    - iii. Cross-examine witnesses.  
**NOTE:** *The Practitioner has the right to purchase a copy of the transcript or tape of the hearing.*
3. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.

4. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.

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

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

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

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

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

The hearing panel chair shall do the following:

- Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
- Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.
- Maintain decorum throughout the hearing.
- Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
- Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.
- Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.
- Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

Practitioner Rights:

- The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.
- 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, accept in part, modify, or reject the review panel's recommendations.

- The Director will issue a written decision within 10 workdays of the day of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.
- The Practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.
- The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the Practitioner's appeal. The decision of the VISN Director is not subject to further appeal.
- A Practitioner 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.
- The review panel hearing defined above 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.
- If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, if greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

5. Revocation of Privileges:

- Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures.
  - i) 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 and VA Handbook 5021 Employee/Management Relations.
  - ii) For probationary employees appointed under 38 U.S.C. 7401(1) and 38 U.S.C. 7405, the proposed revocation will be combined with probationary separation procedures, which constitutes an automatic revocation as contained in VA Handbook 5021 Employee/Management Relations.
- 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. Even though a revocation of privileges requires removal from both employment and appointment to the medical staff, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. For example a surgeon's privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by the Executive Committee of the Medical Staff/Professional Standards Board for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

6. Reporting to the National Practitioner Data Bank: Disclosure of information to the National Practitioner Data Bank and Health Integrity Protection Data Bank for Tort Claim payments and adverse actions of more than 30 days will follow procedures outlined in VHA Handbook 1100.17.

7. Reporting to State Licensing Boards: VA has a responsibility to report to state licensing boards appointed or suspended members of the Medical Staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. Reference VHA Handbook 1100.18
8. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

## **ARTICLE XI. RULES AND REGULATIONS**

1. As may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to identify the level of clinical practice that is required of each member of the Medical Staff and of all others with delineated clinical privileges or practicing under a Scope of Practice, Medical Staff Rules and Regulations may be adopted. Rules and Regulations may be adopted, amended, repealed or added by a majority vote of the members of the Executive Committee of the Medical Staff present and voting at any meeting of that Committee where a quorum exists. Medical Staff Rules and Regulations must be approved by the Director.
2. Basic rules and regulations are prescribed in VA manuals and other VA Central Office directives. In addition, Medical Center Memorandums and Standard Operating Procedures are issued to provide supplemental policies and procedures. Rules and regulations of departments or services will not conflict with each other, with Bylaws, rules regulations and policies of the Medical Staff or requirements of the Governing Body.
3. Each staff member will function within and abide with the rules and regulations as applicable. Service chiefs or designees are responsible that resident/intern physicians, dentists, psychologists, optometrists, and podiatrists assigned to them understand and abide with the rules and regulations as applicable.
4. Medical Staff Rules and regulations consist of, but are not limited to the following:
  - a. Except in an emergency, no patient, except for observation and examination, will be admitted to the hospital until after a provisional diagnosis has been stated in the medical record. Individuals with admitting privileges are members of the Medical Staff. Reference RLR VAMC Medical Center Memorandum, Patient Admission. Exception: Admission to the Domiciliary Residential Rehabilitation Treatment Program may be authorized by the Advanced Practice Nurse assigned to that section of Psychiatry & Mental Health Service. S/he is authorized to admit patients only to those non-acute, rehabilitation beds.
  - b. The physician or dentist member of the Medical Staff to whom the patient is assigned is ultimately responsible for the preparation of a complete medical record. The same quality of patient care is to be provided by all individuals with delineated clinical privileges, within and across departments/services and between all staff members who have clinical privileges.
  - c. (1) A complete history and physical examination will be performed and recorded on each admission within 24 hours after admission by a physician or an oral surgeon. When within a 30 day period an inpatient is readmitted for the same condition, the previous history and physical

examination, with an interval progress note, will suffice provided it contains reason for readmission and any new information. Pre-procedure H & P for both inpatient and outpatient procedures should be completed according to RLR VAMC Medical Center Memorandum reference History & Physical Examinations for Inpatients and Outpatients. Exception: The history and physical examination for patients admitted to the Domiciliary Residential Rehabilitation Treatment Program may be performed by the Advanced Practice Nurse assigned to that section of Psychiatry & Mental Health Service.

(2) The Attending practitioner is responsible for authoring an admission note addressing the condition requiring admission as well as an assessment and plan within 24 hours.

d. Progress notes on new admissions, acute cases and intensive therapy should be written frequently and regularly. Progress notes on chronic long-term cases should be written as needed but no less frequently than monthly. Progress notes will be authenticated by the date and signature of the physician or other responsible member of the medical care team.

e. Under most circumstances, the practitioner is to enter orders and medications electronically directly into the computerized medical record including applicable diagnostic information to justify the service ordered. If not entered electronically complete recording of doctor's orders include date (month, day, year), time (time is important for medicolegal reasons), the name of the practitioner placing the order and applicable diagnostic information to justify the service ordered. Each order is to be immediately authenticated by a legible signature. Telephone/verbal orders shall be discouraged, but it is recognized that there are times when they are appropriate. This policy is outlined in RLR VAMC Medical Center Memorandum, Telephone and Verbal Orders.

f. Except in an emergency, consultation with another qualified physician or dentist is required when in the judgment of the patient's assigned physician or dentist: (a) the patient is not a good risk for operation or treatment, (b) the diagnosis is obscure, and/or (c) there is doubt as to the best therapeutic measures to be utilized. Medical/Dental staff members are obligated to request and provide consultations as needed. Psychiatric consultation and indicated treatment will be requested for and offered to any applicant or any bed patient who has attempted suicide or who has taken a chemical overdose. If refused by the patient, the fact that such services were, at least, offered must be documented in the patient's record.

g. A surgical operation and other procedures shall be performed only after informed consent, as defined in RLR VAMC Medical Center Memorandum, Informed Consent, has been properly obtained and documented. All operations performed shall be fully described by the operating surgeon. The operation report will be dictated immediately following the operative/diagnostic procedure, if possible. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. A post-operative progress note must be written, or directly entered into the patient's health record before the patient is transferred to the next level of care.

h. Patients shall be discharged only on written order of the physician or dentist. The order for discharge must be recorded prior to the release of the patient. Reference RLR VAMC Medical Center Memorandum, Discharge Planning and Hospital Discharge Summaries. Exception: Discharge from the Domiciliary Residential Rehabilitation Treatment Program may be authorized by the Advanced Practice Nurse assigned to that section of Psychiatry & Mental Health Service.

i. The hospital summary should be authored by the staff physician, dentist or housestaff member the day preceding or the day of the patient's release but no later than one calendar day thereafter. Advanced Practice Nurses, with category 2 or 3 clinical functions, may

author inpatient discharge summaries if approval is granted by the physician Service Chief for that specific clinical area. This is essential to complete all required actions on the medical record within the VA-Joint Commission standard of thirty (30) days. The summary should be clear and concise. The attending practitioner is ultimately responsible for the completion of the medical record in its entirety. Reference RLR VAMC Medical Center Memorandum, Completion of Patient Health Records and Hospital Discharge Summaries.

j. All records are the property of the hospital and shall not be removed from the premises except under court order, subpoena or statute. Premises are interpreted to mean within the VA Medical Center.

k. Medical records will include evidence of supervision of the housestaff in accordance with RLR VAMC Medical Center Memorandum Resident Supervision. Attending physician's review will be noted in the medical record and signed by himself/herself.

l. It is the policy of this Medical Center, as an affiliate of the Indiana University Medical Center, to provide adequate and appropriate post graduate medical education to residents in all patient care services. Resident supervision is a shared responsibility between the VA Medical Center and the I.U. School of Medicine as outlined in RLR VAMC Medical Center Memorandum Resident Supervision.

m. All medications shall be administered by, or under the supervision of, appropriately licensed personnel in accordance with approved policy and procedure established with a Service and in accordance with RLR VAMC Medical Center Memorandum Provision of Medications for Inpatients and Outpatients.

n. Emergency services are available 24 hours a day. A physician with appropriate clinical privileges for emergency care is available in house 24 hours a day for consultation.

5. Patient's Rights and Responsibilities: This Organization supports the rights of each patient and publishes policy and procedures to address rights including RLR VAMC Medical Center Memorandums outlining:

Advance Directive for Health Care

The Withholding and Withdrawal of Life-Sustaining Treatment

Informed Consent

Patients' Rights and Responsibilities

6. Transfer of Patients policy is outlined in RLR VAMC Medical Center Memorandum for Inter-facility Inpatient Transfer and Intra-ward Patient Transfer.

7. Investigational Drug usage policy is outlined in RLR VAMC Medical Center Memorandum Research and Investigational Drugs.

8. Completion of Patient Health Records is outlined in RLR VAMC Medical Center Memorandum.

9. Infection Prevention, isolation, standard precautions and reportable cases are outlined in RLR VAMC Medical Center Memorandum.

10. Impaired Health Care Professional - The VHA recognizes its responsibility to assist impaired professionals and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for health care professionals. Refer to policy outlined in RLR VAMC Medical Center Memorandum, Health Status and Impaired Professional Program.

11. Peer Review for quality management is outlined in RLR VAMC Medical Center Memorandum.

## **ARTICLE XII AMENDMENTS**

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing or via e-mail to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from Executive Committee of the Medical Staff. Changes to the bylaws are amended, adopted and voted on by the Organized Medical Staff as a whole and then approved by the Medical Center Director. The Bylaws are amended and adopted by 30% endorsement of the active medical staff.
2. Written text, delivered via e-mail or notice of posting to local VA home page, of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
3. All changes to the Bylaws require action by both the Organized Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.
4. Changes are effective when approved by the Medical Center Director.

## **ARTICLE XIII ADOPTION**

These Bylaws shall be adopted upon recommendation of the Organized Medical Staff via e-mail notice or at any regular or special meeting of the Organized Medical Staff at which a quorum is present. They shall replace any previous Bylaws and shall become effective when approved by the Medical Center Director.

Adopted by Medical Staff on January 23, 2013

RECOMMEND APPROVAL:

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Chowdry-Mujahid Bashir, M.D., M.B.A.

Chief of Staff

APPROVED:

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Thomas Mattice

Medical Center Director