MEDICAL STAFF BYLAWS

AND

RULES AND REGULATIONS

OF

VA NORTH TEXAS HEALTH CARE SYSTEM

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Bylaws

BYLAWS AND RULES OF
THE MEDICAL STAFF OF
VA NORTH TEXAS HEALTH CARE SYSTEM

PREAMBLE

Recognizing 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 within VA North Texas Health Care System (VANTHCS) hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing Veterans Health Administration (VHA) and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the Department of Veterans Affairs (VA), and they do not create any rights or liabilities not otherwise provided for in laws or VA Regulations.

These bylaws, rules and regulations have been based upon the following principles:

That the best interests of the patient must be protected by the joint efforts of administrative and professional personnel;

That all patients of VANTHCS are entitled to care of the highest possible quality;

That such principles are enhanced by an environment in which teaching is an integral part of the program; and

That the development of new knowledge through constant research of disease, preventive health measures and education, and the process of providing health care is essential to the development and maintenance of a high quality patient care environment.

The mission of the Medical Staff of VA North Texas Health Care System is to:

*****Provide high quality and compassionate health care to eligible veterans
*****Develop highly trained medical professionals
*****Integrate academic and patient care functions
*****Provide strong leadership for and a commitment to basic and clinical research
*Provide self governance of members of the medical staff through developing, adopting, amending, and abiding by the Medical Staff Bylaws, Rules, and Regulations.

DEFINITIONS

APPOINTMENT - As used in this document the term refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority for providing patient care services at the facility. Both VA employees and contractors may receive appointment to the Medical Staff.

CLINICAL PRIVILEGES (PRIVILEGES) – The authority and permission granted to a Medical Staff member to provide specific diagnostic and therapeutic medical, dental, surgical, podiatric, mental health, chiropractic, optometric, psychological services, clinical social work services and/or other clinical patient care based on evaluation of the individual's credentials and performance.

CHIEF OF STAFF (COS) - The physician appointed by the Director to serve as the clinical staff leader and primary liaison with the University of Texas Southwestern Medical Center, our primary affiliate medical school. The COS is responsible for the professional, developmental, and clinical competency aspects of the medical staff within VANTHCS. The Deputy Chief of Staff may also assume this role as designated by the Chief of Staff.

DEAN'S COMMITTEE - The Dean's Committee is a committee established by a formal memorandum of affiliation between VANTHCS and the University of Texas Southwestern Medical Center (UTSWMC) and approved by the Under Secretary for Health. It is composed of the Dean (or designee) and senior faculty members of the medical school, appropriate representatives of the Medical Staff of VANTHCS, and other faculty of the school and staff of the facility (including the Associate Director for Patient Care Services) as are appropriate to consider and advise on development, management and evaluation of all educational and research programs conducted at VANTHCS.

DIRECTOR - The Director (″Chief Executive Officer″) is appointed by the Governing Body to act as its agent in the overall management of VANTHCS. The Chief of Staff, the Associate Director, the Associate Director for Patient Care Services, the Assistant Director, and the Assistant Director for Outpatient Services all assist the Director.

EMERGENCY - A circumstance or condition in which serious harm could result to a patient. Emergency can also mean that the life of a patient is in serious danger and that any delay in treatment would increase this danger or cause imminent harm.

EX-OFFICIO – A member of a body or committee by virtue of the position held (non-voting).

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) - A defined time-limited process whereby the organization evaluates the privilege-specific competencies of practitioners who do not have documented evidence of competently performing the requested privilege at this organization or when there is a

question regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process also extends to physician extenders functioning under an approved Scope of Practice. The FPPE is protected under The Federal Privacy Act of 1974 (5 U.S.C. § 522) and under VHA Regulations 77VA10Q.

GOVERNING BODY - The term "governing body" refers to the Under Secretary for Health, the individual to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the VA North Texas Health Care System Director.

MEDICAL STAFF - The term "medical staff" refers to all physicians, osteopathic physicians, dentists, podiatrists, psychologists, chiropractors, clinical social workers, and optometrists who are fully licensed and privileged to provide patient care services independently in VANTHCS. Membership categories of the Medical Staff of VANTHCS are*:*

A. **ACTIVE STAFF** - Consists of all full-time, part-time and intermittent physicians, osteopathic physicians, dentists, podiatrists, psychologists, chiropractors, optometrists, and licensed independent clinical social workers who are professionally responsible for the specific patient care and/or education and/or research activities of VANTHCS and who assume all the functions and responsibilities of membership on the Active Staff. Members of the Active Medical Staff will be appointed to a specific service, are eligible to vote in VANTHCS activities and serve on Medical Staff committees.

B. **ASSOCIATE STAFF** - Consists of independent practitioners who are utilized to supplement the practice of members of the Active Staff in their roles in patient care, education, and/or research*.* This category includes without compensation (WOC), consulting & attending, on-station fee basis, on-station contract, Intergovernmental Personnel Act (IPA), or sharing agreement. Consultants and attendings will be appointed to a specific service and will be permitted to serve on committees.

C. **HOUSE STAFF** - The House Staff will consist of those individuals who are graduates of medical, osteopathic, or dental schools engaged in a formal program of postgraduate training and education within VANTHCS, with or without compensation. The Dean's Committee recommends them for appointment for a limited period of training subject to the regulations of the Department of Veterans Affairs. They are not afforded clinical privileges except as noted below. They will function only under the supervision of a qualified practitioner who has clinical privileges in the area being supervised. However, they are expected to function in a manner that is consistent with the Bylaws and Rules of the Medical Staff. Unless specifically included as voting members, they will serve as ex-officio members on designated hospital committees.

Chief Residents (Medical Service) who supervise more junior residents and fellows are residents allowed to function outside of their training activity (e.g. hired as an Admitting Physician) and must be granted clinical privileges through the usual credentialing process. Chief Residents are either Board Certified or Board Eligible in Internal Medicine.

D. **AFFILIATE STAFF** - Consists of members of the Health Professions who participate directly in the management of patients under the general supervision or direction of Medical Staff members. Individuals who hold membership on the Affiliate Staff will be appointed to a specific service and will carry out their activities subject to service policies and procedures. Affiliate Staff will include, but not necessarily be limited to advanced practice registered nurses (Clinical Nurse Specialists, Nurse Practitioners, Certified Registered Nurse Anesthetists, and Certified Nurse Midwives), clinical pharmacy specialists, nurse anesthetists, and physician assistants. They will be permitted to serve as ex-officio members on committees of the Medical Staff.

The qualifications, clinical duties and responsibilities of specific categories of Affiliate Staff include:

1. **ADVANCED PRACTICE REGISTERED NURSES (APRN)**

a. Qualifications - The APRN is a licensed professional nurse who has successfully completed either at least a Master's Degree in a specific clinical area, or a Practitioner Certification from a National League of Nursing (NLN) accredited school of nursing. The role requires advanced knowledge regarding professional nursing practice and the expanded role of the nurse as a health care provider. APRNs have received the education in didactic and clinical skills sufficient to prepare them for patient care as well as advancement to more independent levels of functioning as their competencies in those areas become demonstrated. The APRN is licensed by a State Board of Nurse Examiners as an Advanced Practice Nurse and must have achieved national certification. The Department of Veterans Affairs utilizes some APRNs who do not meet these educational or certification criteria. Overall responsibility for the clinical practice of the APRN resides with the managing physician who will be available for consultation when clinically indicated. All new APRN staff should have the qualifications defined above.

b. Nursing Service will maintain administrative responsibility for APRNs' licensure since all APRNs must be currently licensed as professional nurses.

c. A clinical scope of practice will be established for the APRN with concurrence by the supervising physician, the chief of the clinical service to which the APRN is assigned, and the Nursing Professional Standards Board, the Chief of Staff, and VANTHCS Director (See VANTHCS Memorandum No. MS-19, "Guidelines for Advanced Practice Nurses").

2. **CLINICAL PHARMACY SPECIALISTS (CPS)**

a. Qualifications include those as outlined in VA Handbook 5005, Part 11, Appendix G15.

b. Pharmacy Service will normally maintain administrative responsibility for CPS's; however licensed pharmacists may be individually supported by an appropriate clinical service. Medical supervision will be as stated in specified scope of practice documents based on an appropriate evaluation and credentialing process.

c. A clinical scope of practice will be established for each CPS via a credentialing review process that includes physician involvement for those clinical services affected. This will be accomplished before the scope of practice is forwarded to the credentialing board for review. Final approval will be according to procedures and policies applying to the credentialing board. Reference VA 5005, Part II, Chapter 3, section B.

3. **NURSE ANESTHETISTS**

a. Qualifications - The individual must be a citizen of the United States, a graduate of a school of nursing approved by the appropriate State Accrediting Agency at the time the program was completed by the applicant, and a graduate of a school of anesthesia approved by the American Association of Nurse Anesthetists.

b. Clinical Duties and Responsibilities - Nurse Anesthetists function as members of an anesthesia care team (Nurse Anesthetist and Physician Anesthesiologist). The training, experience, and demonstrated current competence of nurse anesthetists will be taken into full account when a clinical scope of practice is established for each provider. The Scope of Practice of each provider will be established by the chief of the service with the individual provider. In general, nurse anesthetists will:

1) Exercise judgment in the clinical assessment and recommendations for induction of, maintenance of, and emergence from anesthesia care.

2) Within the Scope of Practice, write orders, record reports, and write progress notes in the medical record. A countersignature by a physician member of Medical Staff will be required for all written medication orders. Orders for diagnostic tests should be included in the scope of practice.

3) Nurse anesthetists will carry out their activities subject to Anesthesiology and Pain Management Service policies and procedures, and in conformity with the applicable provisions of the Medical Staff Bylaws and Rules.

4 **PHYSICIAN ASSISTANT (PA)**

a. Qualifications - The individual must be a citizen of the United States and have either a Bachelor of Science degree (BS) from an AMA/CAHEA accredited program or a BS degree in health-related science with at least 12 months of training in an AMA/CAHEA accredited program. Additionally, all newly hired PAs must be certified by the National Commission of Certification of Physician Assistants.

b. Clinical Duties and Responsibilities - The training, experience, and demonstrated current competence of the physician assistant will be taken into full account in the Clinical Scope of Practice within which each PA will function. The Physician Assistant Clinical Scope of Practice will delineate the routine duties, non-routine duties/non-emergency duties, emergency duties, and miscellaneous activities that they may undertake. (Reference VANTHCS Memorandum No. 11C-04, "Physician Assistants Scope of Practice"). Physician Assistants will be individually assigned to an appropriate clinical service and will carry out activities subject to service policies and procedures, and in conformity with the applicable provisions of the Medical Staff Bylaws and Rules.

ONGOING PROFESSIONAL PRACTICE EVALUATION - (OPPE) - As used in this document is a process by which provider-specific performance data are gathered and evaluated for use in reprivileging as well as for identifying and responding to abnormal clinical practice trends. This process will extend to privileged staff as well as practitioners functioning under an approved Scope of Practice. OPPE is protected under The Federal Privacy Act of 1974 (r U.S.C. 522) and under VHA Regulations 77VA10Q.

ORGANIZED MEDICAL STAFF (MEDICAL STAFF) - The body of Licensed Independent Practitioners who are collectively responsible for adopting and amending medical staff bylaws and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges. This body consists of all active staff members of the medical staff.

PRACTITIONER - A physician, osteopathic physician, dentist, podiatrist, optometrist, psychologist, clinical social worker or chiropractor who is fully licensed or otherwise granted authority to practice in a State, Territory, or Commonwealth of the U. S. or District of Columbia*.*

RULES - Refers to the specific rules that govern the Medical Staff of VANTHCS as set forth in this document. It also refers to formally promulgated VA Regulations.

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

TELEMEDICINE - The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient. Telephone and secure text messages are excluded from this definition.

VA NORTH TEXAS HEALTH CARE SYSTEM (**VANTHCS)** - Consists of the Dallas VA Medical Center, Sam Rayburn Memorial Veterans Center (Bonham, TX), Fort Worth Outpatient Clinic, Tyler Outpatient Clinic, Community Based Outpatient Clinics, and Outreach Facilities.

ARTICLE 1: NAME

The name of this organization will be the Medical Staff of VA North Texas Health Care System (VANTHCS).

ARTICLE 2: PURPOSE

A. Ensure that all patients treated in VANTHCS will receive efficient, timely, and appropriate care that is subjected to quality management practices.

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

C. Establish and ensure adherence to an ethical standard of professional practice and conduct.

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

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

F. Ensure a high level of professional performance of practitioners authorized to practice in the facility through quality management practices and through appropriate delineation of clinical privileges.

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

H. Bring Medical Staff expertise to deliberations by VANTHCS Governing Body.

I. Develop and implement quality management activities in collaboration with VANTHCS staff.

J. Stimulate research activities and assure that research programs are conducted in accord with the standards established by the Research and Development Committee.

ARTICLE 3: MEDICAL STAFF MEMBERSHIP

3.1 Officers

The VA has no requirements for "Officers" of the Medical Staff. The method of selection, qualifications, responsibilities, tenure of office, and conditions and mechanisms for removing from office will be in accordance with applicable VHA Memorandum and Regulation. Referenced policies include: Qualifications, VHA MP-5, Part II, Chapter 2, Appendix B, VHA M-2, Part 1, Chapter 1, "Chief of Staff Responsibilities," MP-5, Part II, Chapter 4 (Probationary Period), Chapter 6 (Proficiency Rating System), Chapter 8 (Disciplinary Actions), Chapter 9 (Separations), or Chapter 10 (Physical Requirements), and the VHA Supplements.

3.2 Leadership

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

B. The Medical Staff, through its committees, boards, functional teams, services and Service Chiefs, provides counsel and assistance to the Chief of Staff and VANTHCS Director regarding all facets of the patient care services and programs including continuous quality and performance improvement, goals and plans, mission and services offered.

C. All Active Medical Staff are eligible for membership on the Executive Council of the Medical Staff (ECMS).

D. Changes to the ECMS membership, leadership, and authority to act may be made by the Medical Staff and proposed directly to the Director. To do so apart from

the recommendation of the COS and the ECMS, a majority of the Medical Staff voting members must vote to make a change. This may be done, for example, by petition, electronic voting, or at a meeting of the Medical Staff in which a majority of all voting members of the Medical Staff is present. The COS or a representative of the Medical Staff must communicate in writing to the Director the outcome of the Medical Staff decision whether the decision is to adopt or vote down the proposed change in ECMS membership, leadership, and authority to act. If adopted, the Director is the final approving authority. The Director will give written notice of the decision to the Medical Staff.

3.3 Membership Eligibility

A. Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, osteopaths, dentists, podiatrists, optometrists, chiropractors, licensed clinical social workers, and psychologists who continuously meet the qualifications, standards, and requirements of VHA, VANTHCS, and these Bylaws. Membership may be considered for other licensed practitioners who are permitted by law to provide patient care services independently and who meet the qualifications, standards, and requirements of VHA, VANTHCS, and these Bylaws. Membership is recommended by the ECMS and approved by the Director.

B. Categories of Medical Staff membership include:

1) Active Medical Staff*
2) Associate Medical Staff*
3) House Staff*
4) Affiliate Medical Staff*

*Fully described under definitions

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

D. Granting of clinical privileges is a prerequisite to appointment as a member of the Medical Staff.

3.4 Qualifications for Medical Staff Membership

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

A. Active, current, full and unrestricted license to practice the individual's profession in a State, Territory, or Commonwealth of the U. S. or the District of Columbia as required for VA employment.

B. Education applicable to individual Medical Staff members as defined, e.g., hold degree of Doctor of Medicine, Osteopathy, Dentistry (DDS and DMD), Podiatry, Psychology, Chiropractic, Social Work, or Optometry from an approved college or university.

C. Relevant training and/or experience consistent with the individual's professional assignment and privileges for which s/he is applying. This includes any internship, residency, board certification, or specialty training.

D. Current competence consistent with the individual's assignment for which s/he is applying.

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

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

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

H. Proficiency of the English language and the ability to communicate effectively with patients, caregivers, staff, and other professional contacts.

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

J. Ability to meet response time criteria established for all clinical bed services.

K. At the time of initial credentialing and recredentialing, evidence must be provided of current Basic Life Support (BLS) training and/or current Advanced Cardiac Life Support (ACLS) certification according to VANTHCS Memorandum 141-09. Providers who have a handicap (i.e. wheelchair bound) may be excused from this requirement upon the recommendation of the Chief of Staff.

3.5 General Responsibilities

Medical Staff Members and others with individual clinical privileges are accountable for and have responsibility to:

A. Provide for continuous care and supervision of their assigned patients at a professionally recognized level of quality and efficiency.

B. Observe Patient's Rights pursuant to 38 CFR 17.33 and as otherwise mandated, in all patient care activities.

C. Actively participate in continuing education, peer review, and Medical Staff monitoring and evaluation, organizational quality improvement activities, and internal and external reviews.

D. Maintain standards of ethics and ethical relationships including a commitment to:

1) Abide by Federal law and VA rules and regulations regarding financial conflict of interest and outside professional activities for remuneration.
2) Provide care to patients within the scope of privileges and advise VANTHCS Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership or to carry out clinical privileges that are held.
3) Advise VANTHCS Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence, or professional conduct within 15 calendar days of notification of such occurrences and their outcome, consistent with requirements under Article IV of these Bylaws.
4) Advise the Director, through the Chief of Staff of any and all changes and/or modifications made to any currently active state medical license within 10 days of noted change and/or modification. Note: A change or modification refers to any alteration to the information on file by the state medical board, to include but not limited to, licensure status change (i.e. restriction/probation), malpractice allegations, criminal charges (i.e., misdemeanors, felonies), convictions, imprisonments, and administrative or judicial professional malpractice proceedings**.**
5) Contribute to, and abide by, high standards of ethics in professional practice and conduct.
6) Work cooperatively with others in the provision of care, treatment and services.

E. Abide by the Medical Staff Bylaws and Rules and all other lawful standards and policies of VANTHCS and VHA.

F. Abide by the decisions of all duly-appointed Medical Staff committees and cooperate in safe patient care, treatment and services and Medical Staff activities, including performance improvement, utilization review, peer review, and Clinical Service meetings.

G. Meet all educational requirements such as training in computer security, information security, and other VHA mandatory training.

H. Assist in any Medical Staff-approved teaching activities for medical students, interns, residents, fellows, nurses, Medical Staff members, and others as required by the Clinical Service of which they are a member.

I. Participate in emergency or other Clinical Service coverage as specified individually in the requirements of the Clinical Service of which they are a member and to respond to consultation requirements as set forth by VHA, the ECMS, or Chief of Staff.

J. Prepare and complete, in accordance with VHA, The Joint Commission (TJC) and other regulatory requirements, the required clinical record of all patients whose care is provided at VANTHCS. Reference, Bylaws, Rules and Regulations, Part VI, Section E, Medical Records.

3.6 Code of Conduct

A. 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.

B. 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 that undermines a culture of safety is a style of interaction with physicians, healthcare system 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 disruptive behavior 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 that undermines a culture of safety may reach a threshold such that it constitutes grounds for further inquiry by the ECMS into the potential underlying causes of such behavior. Behavior by a provider that undermines a culture of safety could be grounds for disciplinary action.

VA distinguishes behavior that undermines 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 that undermines a culture of safety on the part of other providers. VA urges its providers to support their hospital, clinic, practice, or other healthcare organization in their efforts to identify and manage this behavior, by taking a role in this process when appropriate.

C. 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.

3.7 Conflict Resolution and Management

A. For VANTHCS to be effective and efficient in achieving its goals, the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and managing to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program,* addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. The process is also outlined in VANTHCS Memorandum 00-EEO-07.

B. It is expected that VANTHCS medical center leadership will make use of these and other resources in communicating expectations to clinicians and other staff that conflictive, disruptive, inappropriate, intimidating, and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff who experience or witness such behavior are encouraged to advise an appropriate supervisor or other individual in their chain of supervision.

C. Conflict between the ECMS and the Organized Medical Staff on issues including, but not limited to, proposals to adopt a rule or regulation or policy or amendment thereto, shall be referred to the Chief of Staff and will be processed as outlined in Article 3, section 2.D, of these bylaws.

ARTICLE 4: CREDENTIALING APPOINTMENT AND REAPPOINTMENT

4.1 General Provisions

A. Independent Entity: VANTHCS is an independent entity, granting privileges to the medical staff through the ECMS and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical staff appointments and reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical staff practitioners must practice under their privileges or scope of practice.

B. Credentials Review: All practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment, at the time of reappraisal for granting of clinical privileges or scope of practice, or 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 are appointed for a maximum period of 2 years.

C. All members of the Medical Staff as defined in Article 3, and all non Medical Staff Practitioners who hold clinical privileges will be subjected to Focused Professional Practice Evaluation at the time of initial appointment or after a significant break in service or utilization. At the time of re-appraisal for reprivileging, the service chief will utilize Ongoing Professional Practice Evaluation along with all other data in his/her decision whether or not to recommend retention. For further details see VANTHCS Memorandum No. 11-14 "Credentialing and Privileging of Practitioners with Privileges or Scopes of Practice".

D. Appointments to the Medical Staff occur in conjunction with VA employment or utilization under a VA contract or sharing agreement. The authority for these actions is based upon:

1. Provisions of 38 U.S.C. in accordance with Department of Veterans Affairs Manual MP-5, Part II, Chapter 2 and its supplements and to Title 5 regulations 316.402(a), 315.501, 315.502 and applicable Agreement(s) of Affiliation in force at the time of appointment.

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

E. Probationary Period - Initial and certain other appointments made under 38 U.S.C.7401(1), and 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely

evaluated under applicable VA policies and procedures. If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply similar processes to the evaluation of individuals employed under provisions of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements. For further details see VANTHCS Memorandum No. 05-15 "Probationary Periods - Physicians, Dentists, Podiatrists, Optometrists, Nurses, Nurse Anesthetists, Physician Assistants and Expanded Function Dental Auxiliaries".

4.2 Application Procedures

4.2.1 Documentation

A. Applicants for appointment to the Medical Staff must submit a complete application. To be complete, applications for appointment must be submitted by the applicant in electronic form in VHA's secure on-line Federal Credentialing Program application in VetPro and on forms approved by VA and/or the facility. This must include authorization for release of information pertinent to the applicant, as well as information regarding:

1) Items specified for Qualification for Medical Staff Membership:

   a. Active, current, full and unrestricted license;
   b. Education as required for the position;
   c. Relevant training and/or experience;
   d. Current competence;
   e. Physical and mental health status as confirmed on the declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;
   f. English language proficiency;

2) 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 or status as a Permanent Resident, and documentation from the United States Central Immigration Service (USCIS) of employment authorization, verified by Human Resources Management Service and pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.

3) References - Names and addresses of a minimum of three (3) individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges

requested. At least one of the references must be from the current or most recent employer(s) or institution(s) where clinical privileges are or were held. In the case of individuals completing residencies, one reference must come from the Residency Program Director.

4) Previous Employment - List of all health care institutions where the practitioner is/was appointed, utilized or employed, including:

   a. Name of health care institution of practice;
   b. Term of appointment or employment; and
   c. Privileges held and any disciplinary actions taken against the privileges, including suspension, revocation, limitations, or voluntary surrender.

5) Drug Enforcement Administration (DEA) Registration and State Controlled Substance Certification, if applicable:

   a. Registration must be documented for those who have, or have had, DEA registration or a state controlled substance certification.
   b. Previously successful or currently pending challenges to DEA registration or state controlled substance certification or the voluntary relinquishment of such registration must be reported.

6) Challenges to license, including whether a license or registration to practice a healthcare occupation ever held by the practitioner has been suspended, revoked, voluntarily or involuntarily surrendered or not renewed.

7) Status of any claims made against the practitioner in the practice of any healthcare occupation.

   NOTE: Final judgments or settlements of professional liability actions are minimum requirements.

8) 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 against the practitioner by any hospital, licensing board, law enforcement agency, professional group or society.

10) Picture identification to ensure that he/she is the individual identified in the credentialing documents is verified by Human Resources.

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

12) National Provider Identifier (NPI) received from National Plan and Provider Enumeration System (NPPES) as mandated by Health Insurance Portability and Accountability Act of 1996 (HIPAA).

13) Background checks in accordance with Human Resources and Office of Personnel Management regulations.

B. Documents required (primary source obtained by the Medical Staff Office) in addition to those listed include:

1) Documentation of current or most recent clinical privileges held, if available.

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

3) For foreign medical graduates, evidence and verification of the Educational Commission for Foreign Medical Graduates (ECFMG) certificate and/or a fifth pathway route of training.

4) Evidence and verification of board certification, if claimed.

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

6) Evidence of submission of query to National Practitioner Data Bank (NPDB) and Federation of State Medical Boards (FSMB), State Licensing Board (SLB), the Department of Health and Human Services, and Office of Inspector General (OIG), for all members of the Medical Staff and those practitioners with clinical privileges.

7) Confirmation of health status.

8) Results of review of Department of Health and Human Services (DHHS), OIG List of Excluded Individuals and Entities (LEIE).

9) Agreement to abide by the Medical Staff Bylaws and Rules and to provide continuous care of applicant's patients.

NOTE: Verification is defined as 'primary source' documentation by letter, telephone call, computer printout, or, in the case of confirmation of board certification, by listing in specific directories. Competence and relevant training or experience will be established through primary source verification. See VHA Directive 1100.19 and VA Handbook 5005, Part II, Chapter 3, Section B.

4.2.2 Burden of Proof

The applicant has the burden of obtaining and producing all needed information for a proper evaluation of 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 45 days of request may serve as a basis for denial of consideration for employment.

4.3 Process and Terms of Appointment

A. The chief of the service to which the applicant is to be assigned is responsible for recommending appointment to the Medical Staff based on evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.

B. The ECMS recommends Medical Staff appointment based on evaluation of credentials of each applicant.

C. Appointments to the Medical Staff should be acted upon by the VANTHCS Director within 45 days of receipt of a fully complete application including all required verifications, references and recommendations from the appropriate service chief and ECMS.

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

D. Any time periods specified in this section that are created to help those accomplishing the Credentialing and Privileging process do not imply any rights of the applicant to have his/her application processed within these same time periods.

E. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment. In the case that the appointment is not approved, reasons will be provided.

4.3.1 Expedited Appointment

There may be instances in which expediting a medical staff appointment for licensed independent practioner (LIP) is in the best interest of high quality patient care. Requirements for expedited appointment are as follows:

a. The Practitioner must submit a completed application through VetPro.

b. The Health Care System:

(1) Verifies education and training;

(2) Verifies one active, current, unrestricted license from a State, Territory, or Commonwealth of the United States or the District of Columbia;

(3) Receives confirmation on the declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;

(4) Queries licensure history through the Federation of State Medical Boards (FSMB) Physician Data Center and receives a response with no report documented;

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

(6) Verifies current comparable privileges held in another institution; and

(7) Receives a response from NPDB-HIPDB PDS registration with no match.

(8) Verifies that there are no current or previously successful challenges to licensure.

(9) Verifies that there is no history of involuntary termination of medical staff membership at another organization.

(10) Verifies that there is no history of voluntary limitation, reduction, denial, or loss of clinical privileges.

(11) Verifies that there is no history of final judgments adverse to the applicant in a professional liability action.

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

d. The recommendation must be acted upon by the Director.

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

An applicant for privileges is ineligible for the expedited process if any of the following has occurred:

a. The applicant submits an incomplete application.

b. The ECMS makes a final recommendation that is adverse or has limitations

4.3.2 Temporary Appointment

When there is an emergent or urgent patient care need, a temporary VA employment appointment, under the provisions of 38 U.S.C. 7405 (a) (1) and VA Handbook 5005, Part II, Chapter 3 a temporary Medical Staff appointment may be approved by VANTHCS Director or the Acting Director, in the absence of the Director, upon recommendation of the Chief of Staff or the Acting Chief of Staff. Verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted, initiation of a NPDB query, and a reference will be obtained prior to making such an appointment.

Examples of when a temporary medical staff appointment for urgent patient care needs may be made are:

1. Situations in which a physician becomes ill or takes a leave of absence and a LIP would need to cover the physician's practice until the physician returns.

2. Situations in which a specific LIP with specific skills is needed to augment the care to a patient that the patient's current privileged LIP does not possess.

If the Temporary appointment is not converted to another form of medical staff appointment, complete credentialing must be completed, even if completion occurs after the practitioner's temporary appointment is terminated or expires. At a minimum, the LIP must submit a VetPro application, and all credentials must be verified. If unfavorable information was discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

NOTE: *Temporary appointments for urgent patient care needs may not exceed the length of time of the Temporary privileges as defined under Article 5, Section 9.D.*

4.4 Reappointment

E. Reappointment to the medical staff occurs no less than every two years and is based on a recommendation from the Service Chief to the ECMS. Final approval is granted by the Director. Service Chiefs are expected to utilize all available data including Ongoing Professional Practice Evaluation, direct observation, training, recommendations from peers, and any other information available.

F. ECMS may require additional information to assess current competency. In making such determinations and recommendations for re-appointment, the Clinical Service Chief will consider the member's performance with regards to the American College of Graduate Medical Education (ACGME) 6 general competencies of Patient Care, Medical/Clinical Knowledge, Practice-Based

Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice.

ARTICLE 5: CLINICAL PRIVILEGES

5.1 General Provisions

A. VA North Texas Health Care System specific Medical Staff privileges are granted for a period of up to two (2) years.

B. As noted in section 4.4, biennial reappraisal of all practitioners who hold clinical privileges is required and will be accomplished utilizing the VetPro system. Reappraisal includes a review of performance and an evaluation of the individual's physical and mental status, peer appraisals and assessment of the individual's current privileges. It also requires documented evidence of relevant ongoing continuing medical education (CME). This can include activities pertaining to faculty positions where they serve to advance clinical knowledge and skills. Reappraisal is initiated by the practitioner's service chief at the time of a request by the practitioner for new and renewed clinical privileges.

C. A practitioner's request for modification/enhancement of existing clinical privileges is made by the practitioner's submission of a formal request for a desired change(s) with full documentation to support the change. Current written information (evidence-based evaluation of competence) may be used for evaluation of requests for additional privileges. Modification of privileges will be accomplished utilizing the VetPro system as done at the time of reappointment. A Focused Professional Practice Evaluation is required for all new privileges granted to a practitioner.

D. Other licensed practitioners (associate health professionals) who are presently permitted by law and VANTHCS to provide patient care services independently, will function under an approved scope of practice.

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

F. Practitioners with clinical privileges are assigned to and have clinical privileges in one clinical department/service, but may be granted clinical privileges in other clinical departments/services.

G. Exercise of clinical privileges within any service is subject to the rules of that service and to the authority of that service chief.

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

Note: Gender, race, creed, and national origin will not be used in making decisions regarding granting or denying of clinical privileges.

5.2 Process and Requirements for Requesting Clinical Privileges

A. Burden of Proof - Also described in section 4.2.2. The practitioner requesting clinical privileges must furnish all information needed for a proper evaluation of professional competence, conduct, ethics and other qualifications. The information must be complete and verifiable. The practitioner is responsible for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 45 days of request may serve as a basis for denying clinical privileges.

B. A practitioner's request for clinical privileges must be made in writing and include privileges requested "within well defined limits" (e.g., procedure/disease classifications) in a format approved by the Medical Staff. Typically, this request comes from the clinical service chief under whom the practitioner will be working and is given to the Credentialing office.

C. The practitioner applying for initial clinical privileges must submit a complete application that includes:

1) Complete appointment information as outlined in Article 4.2, unless otherwise specified.

2) Application for clinical privileges.

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

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

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

3) Physical and mental health status as it relates to his/her ability to function within privileges requested must be documented in their credentials file. VHA Handbook 1100.19 requires a signed health statement indicating that no health problems exist that could affect the practitioner's practice and this is confirmed by their new Service Chief. When applicant's ability (based on health) to perform privileges is in doubt, an evaluation by an external and/or internal source may be required.

4) Continuing Medical Education (CME) that meets their state licensing board requirements for licensure renewal. The CME must be related to the area and scope of clinical privileges taken during the two-year period being examined for reappraisal. (Other independent practitioners will comply with their state licensing board for CME requirements, i.e., psychologists, dentists, optometrists, podiatrists, licensed clinical social workers, and chiropractors)

5) Status of all licenses and certifications held.

6) Any sanction(s) by a hospital, state licensing agency or any other professional health care organization including while working for VANTHCS via moonlighting, private practice, etc.; voluntary or involuntary relinquishment or termination of licensure, registration, medical staff membership; or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; any malpractice claims, suits or settlements; reduction or loss of privileges at any other hospital within 15 days of the adverse action.

7) Advise the Director, through the Chief of Staff of any and all changes and/or modifications made to any currently active state medical license within 10 days of noted change and/or modification. Note: A change or modification refers to any alteration to the information on file by the state medical board, to include but not limited to, licensure status change (i.e., restriction/probation), malpractice allegations, criminal charges (i.e., misdemeanors, felonies), convictions, imprisonments, and administrative or professional judicial malpractice proceedings**.**

8) Names of other hospitals at which privileges are held and copies of the privileges held.

E. **Bylaws Receipt and Pledge**. Prior to the granting of clinical privileges, Medical Staff members or applicants will receive a copy of the Bylaws and sign an electronic pledge as stated in the on-line VetPro credentials application, agreeing to provide for continuous care of their patients and to abide by the professional obligations therein.

F. **Verification**

1. Verification of credentials prior to granting of initial privileges will be accomplished as described in Article 4, Section 2, “Application Procedures.”

2. Before granting subsequent clinical privileges, the Chief of Staff will ensure that the following information is on file and verified with primary sources, as applicable:

a. Current and former licenses in all states

b. Current and former DEA license and/or registration and state controlled substance certification when required, such as in some contracts or fee basis
c. National Practitioner Data Bank query
d. Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)
e. Physical and mental health status information from applicant
f. Physical and mental health status confirmation and professional competence information from peers, and/or Service Chief
g. Continuing education
h. Board certification(s)
i. Quality of care information

5.3 Credentials Evaluation and Maintenance

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

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

C. A complete and current Credentialing and Privileging file including the electronic VetPro file will be established and maintained for each practitioner requesting privileges. These files will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging. At any time that a credentialing file is found to lack required documentation for any reason, effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the file stating the reason. The entry will also detail the effort made to obtain the information, with dates and signature of the individuals responsible for the effort.

D. Privileges may be reduced or terminated voluntarily at any time, if Medical Staff members make formal requests for such reductions or terminations and give full explanations why such requests should be granted.

5.4 Recommendations and Approval

A. Peer recommendations will be obtained from individuals who can provide authoritative information regarding training/ experience, professional competence, conduct, and health status. Peer recommendations should include written information regarding the practitioner's current:

1. Medical/Clinical Knowledge
2. Technical and Clinical Skills
3. Clinical Judgment
4. Interpersonal Skills
5. Communication Skills
6. Professionalism

B. The service chief to whose service the applicant for clinical privileges is assigned is responsible for assessing all information, both initially and for reappraisal, and recommending approval of clinical privileges. This responsibility includes queries to all other facilities where the practitioner has held or holds privileges.

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

2) Recommendation for clinical privileges subsequent to those granted initially will be based on, at least, reappraisal of physical and mental health status, peer recommendations from two (2) peers of the same specialty (other than the Service Chief), continuing education, professional performance, judgment and clinical and/or technical skills, and service specific provider profile information. Service specific profile may include, but is not limited to, appraisal of technical skills, quality of care including results of monitoring, performance improvement activities, evaluation activities such as surgical case review, drug usage evaluation, medical record review, blood usage review, pharmacy and therapeutics review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, customer satisfaction, consult usage, infections, mortality, restraint usage, moderate sedation, utilization management, autopsy, aggregate practitioner data as applicable, and clinical service and/or facility monitors. The Clinical Service Chief and, if applicable, the Clinical Section Chief will complete the "Assessment by Section and Service Chief for Renewal of Clinical Privileges" attestation page that denotes a provider's current competence and performance activities during the past renewal cycle. It also requires documentation of continuing medical education that complies with state licensure renewal requirements. For providers with little to no VA patient activity during their reprivileging cycle, letters of recommendation in the form of a competency questionnaire will be sent to the department chairs or Service Chiefs at other facilities where the provider has privileges.

C. The ECMS recommends the granting of clinical privileges based on each applicant's successfully meeting the requirements for clinical privileges as specified in these Bylaws.

D. Clinical privileges are acted upon by the VANTHCS Director within 45 days of receipt of a completed application that includes all requirements set forth above in Section 5.2.

E. Original approved clinical privileges documents are placed in the individual practitioner's Credentialing and Privileging folder and copies are distributed to the practitioner. Privileges can also be accessed through the intranet.

F. Any changes made to a practitioner's request for clinical privileges during the review and approval process must be well documented to include all communication with the practitioner and the reason for the changes. Removal or non-renewal of requested privileges may require appropriate due process proceedings as this may require reporting to the National Practitioner Data Bank.

5.5 Renewal of Clinical Privileges

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

1. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.
2. Supporting documentation of professional training and/or experience not previously submitted.
3. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges, confirmed by a physician acceptable to the Organized Medical Staff.
4. Documentation of continuing medical education related to area and scope of clinical privileges, not previously submitted.
5. 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.
6. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

7. 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.
8. Names of other hospitals or facilities at which privileges are held and requests for copies of current privileges held.

B. Verification: Before granting renewal of clinical privileges, the Medical Staff Office will ensure that the following information is on file and verified with primary sources, as applicable:

1. Current and previously held licenses in all states.
2. Current and previously held DEA/State CDS registration.
3. NPDB-HIPDB PDS Registration.
4. FSMB query
5. Physical and mental health status information from applicant.
6. Physical and mental health status confirmation.
7. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and FPPE.
8. Continuous education to meet any local requirements for privileges requested.
9. Board certifications, if applicable.
10. Quality of care information.

5.6 Ongoing Professional Practice Evaluation (OPPE)

A. OPPE allows the Medical Staff to identify, on an ongoing basis, professional practice trends that may impact quality of care and patient safety. Each service will define specific criteria relevant to that service and will maintain an up-to-date OPPE file on each credentialed provider (and those functioning under an approved scope of practice). Specific criteria should include (but not be limited to):

1. Quality of patient care
2. Medical/clinical knowledge
3. Practice-based learning improvement
4. Interpersonal communication skills
5. Professionalism
6. Systems based practice

B. OPPE data must be aggregated and may come from a variety of sources consisting of but not limited to data that are not integrated into performance improvement activities. Indicators will be developed by the services and approved by the ECMS to include consideration and monitoring of the following areas, if applicable:

1. Appraisal of technical skills
2. Autopsy policy compliance
3. Blood usage
4. Consult usage
5. Continuing medical education
6. Customer satisfaction/complaints
7. Days worked
8. Infections
9. Medical records completion
10. Medication usage
11. Meeting and committee attendance
12. Moderate sedation
13. Mortality rates
14. Operative and other procedures performed and their outcomes
15. Peer recommendations
16. Peer reviews (now called clinical pertinence reviews for service level monitoring and not to be confused with Protected Peer Review conducted by Clinical Quality Management)
17. Performance improvement activities
18. Requests for tests or procedures
19. Resident supervision
20. Restraint usage
21. Resuscitations
22. Risk management
23. Tort claims filed, reports to the National Practitioner Data Bank, non-VA claims paid
24. Training and mandatory testing
25. Utilization management

C. In using aggregate data, the service chief will compare the individual practitioner against the aggregate, when feasible (i.e., data that are not collected for the specific purpose of specific care issues or resource utilization). Data will be collected by each service by means such as a review by peers of medical records, direct observation, monitoring of diagnostic and treatment techniques and may also include collection of information from other members of the health care team. Data on provider workload and provider practice patterns will also be available by downloading a provider's profile via a VistA software program.

D. Data on each provider will be reviewed by the service chief or his/her designee and will include aggregate data, when appropriate, for the comparison of providers with their peers.

E. Documentation of OPPE for each provider will be maintained by the service and will include service derived data as well as other information provided biannually by Clinical Quality Management.

F. Thresholds will be established for each indicator in order to help facilitate identification of abnormal practice trends. When thresholds are exceeded, a defined process for evaluation will result as delineated in the "thresholds" attachment to VANTHCS Memorandum No. 11-11 "Ongoing Professional Practice Evaluation".

5.7 Focused Professional Practice Evaluation (FPPE)

A. FPPE is a defined, time-limited process whereby the organization evaluates the privilege-specific competence of practitioners who do not have documented evidence of competency performing privileges they have requested at this organization or when there is a question regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process also extends to physician extenders functioning under an approved Scope of Practice. FPPE will be undertaken in the following circumstances:

1. On all newly hired clinical practitioners.

2. When there is a question regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This may arise as result of review of OPPE data, reports of contact, clinical pertinence review results, risk management activities, observation by other employees, executive concerns, or any source where evidence of clinical practice is monitored.

3. For all new privileges requested, unless otherwise recommended by ECMS and approved by the Director.

4. When there is a sentinel event associated with a specific practitioner, a serious practitioner specific complaint, a provider-specific tort settlement, significant safety violation, or repeated or egregious unprofessional behavior.

5. When the Peer Review Committee's threshold for a service-specific FPPE referral is met.

6. When a provider returns to duty after an extended absence of greater than nine months from clinical activity.

The complete FPPE process is further outlined in VANTHCS Memorandum No. 11-03 "Focused Professional Practice Evaluation".

5.8 Additional Privileges

A. Practitioners who have completed required training in new procedures outside VANTHCS must submit, in writing, a request for approval to perform the new procedure. The written request must include copies of documentation of training and a letter from the course proctor stating the completion date of training and number of cases performed. Once the written request has been received by the Medical Staff Office, the process for renewal of clinical privileges for the provider

will be initiated and completed as described in section 5.5 above. The written request must be approved by his/her section chief and/or service chief, ECMS and the VANTHCS Director. A FPPE will be initiated at the beginning of performance of the new privilege at VANTHCS.

B. Proctors from outside VANTHCS providing in-service training are required to submit, in writing, a request for temporary privileges. In addition, practitioners undergoing in-service training must submit, in writing, a request for an amendment to their clinical privileges showing these procedures to be performed under supervision. Once the training has been completed, the trainee must follow the procedure outlined in paragraph A above.

C. The ECMS, Clinical Service Chiefs, the Chief of Staff, and/or the Director of VANTHCS reserve the right to recommend denial of additional privileges if evidence exists that the resources to adequately care for patients under the conditions of these additional privileges do not exist or if the privileges are not required for the position held.

5.9 Exceptions

A. Teleconsultation and Telemedicine Privileges

1. When utilizing TJC accredited hospitals or ambulatory care organizations for telemedicine or teleconsultation, VANTHCS may use the credentialing and privileging decision from the site providing the care if :

   a. The practitioner is appropriately credentialed and privileged to provide this care at the site providing the telemedicine or teleconsultation; and

   b. A formal agreement (e.g. memorandum of understanding (MOU), contract, sharing agreement, etc.) is in place between the two organizations. This agreement defines that:

      1) The facility accepting these telemedicine or teleconsultation services (the site of the patient) has evidence of internal reviews of the practitioner's performance of those privileges and reports to the distant site (the site of the practitioner delivering the services) any quality of care concerns that are useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes.

      2) The facility providing these services will report to the facility receiving the services any quality of care concerns that occur. At a minimum, this information includes all adverse outcomes.

2. For VA purposes, telemedicine providers must have a medical staff appointment in at least one VA medical facility. This requirement will assure that the telemedicine provider is credentialed and privileged in accordance with

VA standards. This facility where the telemedicine provider is credentialed and privileged will serve as a TJC accredited entity for the purposes of this process. Even though other VA entities may be utilizing the services of the telemedicine provider through MOU, contract, or other agreement with a non-VA entity, a MOU with the VA medical facility serving as TJC accredited entity is required.

3. In the case of contract practitioners, it should be noted that some states do not allow telemedicine and/or teleconsultation across state lines, unless the provider is licensed in the state where the patient is physically located. VHA has a General Counsel opinion from 2006 that indicates that in these states, the clinical indemnity coverage of contract practitioners may be void, even if they are credentialed and privileged by VA. Prior to the commencement of services by the contract practitioners providing telemedicine and/or teleconsultation or remotely monitoring physiology data from veteran patients, the state regulatory agency in the state in which the practitioner is physically located as well as the state where the patient is physically located, must be consulted. When dealing with Federal entities, additional licenses that authorize the provision of telemedicine and/or teleconsultation services in the relevant states may not be required. The opinion of the Regional Counsel must be sought in these matters.

B. Disaster Privileges

Disaster privileges may be granted when the facility has activated the emergency management plan. Disaster privileges will be granted under the provisions of VHA Handbook 1100.19. At a minimum before disaster privileges can be granted the LIP must provide evidence of a current photo ID card and evidence of a current license to practice. Disaster Privileges shall not exceed 10 calendar days. Full reference is in the VANTHCS Emergency Operations Plan (EOP).

C. 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. Properly supervised members of the house staff may also provide emergency care.

D. Temporary Privileges for Urgent Patient Care Needs

Temporary privileges for health care professionals in the event of emergent or urgent patient care needs may be granted by the Director at the time of a temporary appointment. Such privileges must be based on documentation of a current State license and other reasonable, reliable information concerning training and current competence. The recommendation for temporary privileges must be made by the Chief of Staff and approved by the Director. Temporary privileges are not to exceed 60 calendar days.

ARTICLE 6: FAIR HEARING AND APPELLATE REVIEW

6.1 Denial of Medical Staff Appointment

When review of credentials and recommendations contained in a complete application results in denial of appointment, the applicant will be notified by the Chairperson of the ECMS, through a letter signed by the VANTHCS Director. The notification will briefly state the basis for the action.

6.2 Self-Governance Actions

A. The Director acts as the Governing Body of VANTHCS and is responsible for proper and efficient management of the facility.

B. The Chief of Staff is the senior administrative physician in charge of professional services. The Chief of Staff plans, directs and coordinates activities of the clinical professionals and has direct responsibility for organization and administration of the Medical Staff and for proper functioning of the clinical organization. The Chief of Staff is directly responsible to the VANTHCS Director for the quality of professional care provided in the facility.

C. Each clinical service, which is a component of the Medical Staff, is directed by a Service Chief or Associate Chief of Staff (ACOS). Responsibilities of the Service Chief/ACOS include:

1. Being accountable for all professional and administrative activities within the service.

2. Monitoring the quality and appropriateness of patient care and professional performance provided by members with clinical privileges in the service through a planned and systematic process. This includes patient care review, ongoing monitoring of practice and clinical quality measures, credentials review and privileges delineation, medical education, and utilization review.

3. Recommending clinical privileges for each member of the service.

4. Being involved in planning VANTHCS facilities, equipment purchases, and continuing education programs. This includes responsibility and accountability for budgetary and fiscal aspects of service administration.

6.3 Actions Against Clinical Privileges

A. 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, Behavior

or Behaviors That Undermine a Culture of Safety, 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 Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Staff promptly notifies the Director in writing 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 performance 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. The investigation process does not preclude managers and supervisors from exercising their rights and their responsibility to pursue investigations regarding conduct, performance, attendance, and other operational issues involving the employees whom they supervise, as referenced in VHA Handbook 5021.

B. Fact Finding Process: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of section 6.3, a fact-finding process will be implemented. This fact-finding process should be completed within 30 days or there must be documentation as to why that was not possible. Pursuant to the investigation, the Practitioner being investigated has an opportunity to discuss, explain, or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article 6 of these Bylaws apply thereto. A fact-finding investigation is an administrative matter and is not an adversarial Hearing. 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, Behavior or Behaviors That Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, the Chief of Staff may recommend that the Director impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by an Ad Hoc Investigative Team.

C. 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, any or all of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Director.

1. The Chief of Staff convenes the Ad Hoc Investigative Team to investigate the matter, meet with the Practitioner if requested, and make a report thereof to the

ECMS within fourteen (14) days, unless clinical review cannot be obtained within this timeframe, after the effective date of the Summary Suspension.

2. Immediately upon the imposition of a Summary Suspension, the Service Chief or the Chief of Staff provides or assigns alternate medical coverage for the patients of the suspended Practitioner.

D. Automatic Suspension of Privileges: An Automatic Suspension occurs immediately upon the occurrence of specific events.

1. The medical staff membership and clinical privileges of any Practitioner with delineated clinical privileges shall be automatically suspended if any of the following occurs:

    a. The Practitioner is being investigated, indicted, or convicted of a misdemeanor or felony that could impact the quality of care or safety of patients.

    b. The Practitioner is being investigated for fraudulent use of a Government credit card.

    c. The practitioner fails to maintain the mandatory requirements for membership of the medical staff.

2. For matters requiring further investigation, the Chief of Staff convenes the Ad Hoc Investigative Team to investigate the matter and to make a report thereof to the ECMS within fourteen (14) days, unless clinical review cannot be obtained within this timeframe, after the effective date of the Automatic Suspension. For matters not requiring further investigation, a report will be made to ECMS.

3. Immediately upon the occurrence of an Automatic Suspension, the Service Chief or the Chief of Staff provides or assigns alternate medical coverage for the patients of the suspended Practitioner.

4. If there is more than one automatic suspension 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.

E. Review by the Ad Hoc Investigative team: The Ad Hoc Investigative Team investigates the charges and makes a report of the investigation to the ECMS within fourteen (14) days, unless clinical review cannot be obtained within this timeframe, after the Investigative Team has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the investigative team to discuss, explain or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article 6 of these Bylaws apply thereto. An investigation by the Ad Hoc Investigative Team is an administrative matter and not an adversarial Hearing. A record is made and included with the team’s findings, conclusions, and recommendations reported to the ECMS.

F. ECMS Recommendation: Within fourteen (14) days after receipt of a report from the Ad Hoc Investigative Team, the ECMS makes a recommendation based on the request. If the recommendation being considered by the ECMS involves a reduction, suspension, or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the ECMS prior to the committee's action on such request. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article 6 of these Bylaws apply thereto. A record is made by the ECMS.

1. The ECMS may reject or modify the recommendations; issue a warning; recommend a letter of admonition or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension, or revocation of one or more 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.

2. Any recommendation by the ECMS 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 6 of these Bylaws.

G. When recommendations regarding clinical privileges are adverse to the applicant, including but not limited to reduction and revocation, procedures in VHA policy on credentialing and privileging of physicians and dentists will be followed (VHA Handbook 1100.19, Credentialing and Privileging).

H. Generally, disciplinary and performance based privilege changes are undertaken after due process procedures consistent with those outlined in VHA policy (Handbooks 1100.19 and 1100.17) on credentialing and privileging and National Practitioner Data Bank Reports, as applicable, are exhausted. The mechanism for fair hearing is also delineated in the VHA Handbook.

I. When specific clinical privileges are contingent upon appointment to the faculty of affiliates, loss of faculty status results in automatic administrative suspension and termination of those privileges specifically tied to the faculty appointment.

J. Actions Not Constituting Corrective Action: The ECMS 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:

1. The appointment of an Ad Hoc Investigation Team;

2. The conduct of an investigation into any matter;

3. 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, 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;

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

5. 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;

6. The issuance of a letter of warning, admonition, or reprimand;

7. Corrective counseling;

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

9. 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.

6.4 Reporting Adverse Actions

A. Disclosure of information to State licensing boards regarding practitioners separated from VA service will be completed in accordance with VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards.

B. Disclosure of information to the National Practitioner Data Bank through State licensing boards regarding adverse action against clinical privileges of more than 30 days will follow provisions of the VHA Handbook 1100.17 titled National Practitioner Data Bank Reports.

6.5 Reduction and Revocation of Privileges

A. Reduction of privileges may include, but is not limited to, restricting or prohibiting performance of selected specific procedures, or prescribing and/or dispensing controlled substances. Reduction of privileges may be time-limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area. Requirements of 38 U.S.C. are protective of full time permanent staff and therefore will likely result in duplicate hearings. The procedures for reduction and revocation will be followed according to VHA policy on credentialing and privileging of physicians and dentists (VHA Handbook 1100.19, Credentialing and Privileging, VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, VHA Handbook 1100.18, Reporting to State Licensing Boards).

B. Revocation of privileges refers to the permanent loss of all clinical privileges.

C. 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 a discussion of the reasons for the change. The notice should also indicate that if a reduction or revocation is effected based on the outcome of the proceedings, a report will be filed with the NPDB, with a copy to the appropriate State Licensing Board in all states in which the practitioner holds a license and in the state in which the facility is located. The notice will include a statement of the practitioner's right to be represented by an attorney or other representative of the practitioner's choice throughout the proceedings.

D. The practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following the review, the practitioner may respond in writing to the Chief of Staff's written notice of intent. The practitioner must submit a response within ten (10) workdays of receipt of the notice of intent. If requested by the practitioner, an extension may be granted at the discretion of the Chief of Staff and Director.

E. All information developed up to this point with respect to the proposed reduction of a member's privileges will be forwarded to the Director for a decision. If the practitioner disagrees with the Director's decision, a hearing may be requested. The practitioner must submit the request for hearing within five (5) workdays after receipt of the decision.

F. Upon receipt of a request for a hearing, the Director will appoint a review panel of three professionals within five (5) workdays to conduct a review and hearing. At least two members of the review panel will be members of the same profession. During the hearing, the practitioner has the right to be present throughout evidentiary proceedings, be represented by counsel or a representative of the member's choice to cross-examine witnesses, and to purchase a copy of the transcription of the proceedings. The panel will complete its review and submit its report to the Director within fifteen (15) workdays of its completion.

G. Upon receipt of the panel's report, the Director has the authority to accept, reject, accept in part, or modify the review panel's recommendations. The Director will issue a written decision within ten (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 reasons for the change. The signature of the Director constitutes a final action, and the reduction is reportable to the NPDB.

H. If the practitioner wishes to appeal the Director's decision, s/he may submit a written appeal to the Director, Veterans Integrated Service Network (VISN17) within five workdays of receipt of the decision. This appeal option will not delay the submission of the NPDB report. The VISN Director will provide a written decision based on the record within twenty (20) workdays. The decision of the VISN Director is final.

I. Recommendations to revoke a practitioner's privileges will be made by the ECMS, based upon review and deliberation of clinical performance and professional conduct information. When revocation of privileges is proposed and combined with a proposed demotion or dismissal, the due process rights of the practitioner will be afforded by the hearing provided under the dismissal process. Dismissal constitutes a revocation of privileges, whether or not there was a separate and distinct privileging action, and will be reported without further review or due process to the NPDB. When revocation of privileges is proposed and is not combined with a proposed demotion or dismissal, the due process procedures under reduction of privileges above will pertain.

J. After due process has been completed, the Service Chief will take appropriate measures to reduce or limit privileges, to discharge the full-time permanent employee or to separate a non-permanent employee. Such procedures will be conducted in a timely fashion and will be coordinated with the Chief, HRMS or a designee.

K. Loss of partial or complete clinical privileges including separation because of physical or mental disability will be processed in accordance with Federal law and VHA regulations. In the event of a possible agency-initiated disability retirement, representation will be allowed as provided by law.

L. In instances where revocation of privileges is proposed for permanent employees appointed under 38 U.S.C. 7401 (1), the revocation will be combined with proposed action to discharge the employee under 38 U.S.C., Part V, Chapter 74)

M. For probationary employees appointed under 38 U.S.C. 7401 (1) the proposed revocation will be combined with probationary separation procedures contained in MP-5, Part II, Chapter 4 and its VHA supplement. For employees appointed under 38 U.S.C. 7405, the proposed revocation will be combined with action to separate the employee under the provisions of MP-5, Part II, Chapter 9 and its VHA supplement.

N. When the revocation of privileges is proposed for employees not covered above, consideration must be given to discharging or removing the employee, as applicable.

6.6 Suspensions

A. The Director may, on the recommendation of the Chair, ECMS, summarily suspend (30 days or less) privileges, on a temporary basis, pending the outcome of formal action when there is sufficient concern regarding patient safety or specific practice patterns consistent with requirements outlined in VHA Handbook 1100.19, Credentialing and Privileging. When summary suspension is being considered, legal counsel will be advised and consulted. Legal counsel should be sought early when the performance of a member of the Medical Staff is such that, in the opinion of the Clinical Service Chief or higher level supervisor, the staff member's continued exercise of clinical privileges would likely lead to serious harm to

patients.

B. Automatic suspension of clinical privileges shall occur whenever the license (or equivalent legal credential) of a Medical Staff member is revoked or restricted, or if the individual fails to renew the professional license prior to expiration. The automatic suspension shall be for the same time period that such license (or equivalent legal credential) is suspended. No right to a hearing or appellate review exists under these conditions.

C. Automatic suspension of the right to prescribe medications covered by Drug Enforcement Agency (DEA) number will occur whenever a DEA number is revoked or suspended. The Medical Staff member is immediately and automatically divested of any right to prescribe covered by the DEA number. No right to a hearing or appellate review exists under this condition.

D. Clinical privileges of members of the Medical Staff may be administratively suspended for major or intractable delinquencies of medical records or for failure to meet other professional obligations.

6.7 Reporting Malpractice Payments

Disclosure of information regarding malpractice payments, determined by an off-station peer review panel related to substandard care, professional incompetence, or professional misconduct on the part of the practitioner will follow provisions of VHA Handbook 1100.17, entitled “National Practitioner Data Bank Reports (NPDB)”, and Policy Statement OOQ-5 “Tort Claims Analysis and Reporting”.

6.8 Termination of Appointment

Termination of Medical Staff appointment will be accomplished in conjunction with, and will follow, procedures for terminating appointments of practitioners set forth in VA Handbook and Directive 5021, VHA Handbook 1100.17, VHA Handbook 1100.18 and VHA Handbook 1100.19.

6.9 Impaired Provider

VANTHCS provides for a mechanism to educate and address the Medical Staff about licensed independent practitioner health issues, address prevention of physical, psychiatric or emotional illness and to facilitate confidential diagnosis, treatment and rehabilitation of those practitioners who suffer from a potentially impairing condition. See VANTHCS Memorandum No. 11-09, “Management of Impaired Independent Practitioner” for further details.

ARTICLE 7: ORGANIZATION OF THE MEDICAL STAFF

7.1 Officers

See Article 3, Section 3.1

7.2 Leadership

See Article 3, Section 3.2

7.3 Clinical Services

7.3.1 Characteristics

A. Organized to provide clinical care and treatment under leadership of the service chief.

B. Hold service-level meetings and document them via minutes at least quarterly.

C. The following services shall be organized as a component of the medical staff and shall have a service chief or Associate Chief of Staff responsible to the Chief of Staff for the functioning of the service and for the overall supervision of the clinical work within the service. The clinical staff of the VANTHCS shall be organized into the following services.

Ambulatory Care
Anesthesiology & Pain Management Service
Bonham Domiciliary
Central Dental Laboratory
Dental Service
Education
Geriatrics and Extended Care Service
Medical Service
Mental Health
Nuclear Medicine Service
Radiology Service
Radiation Oncology Service
Research & Development
Pathology and Laboratory Medicine Service
Physical Medicine and Rehabilitation Service
Spinal Cord Injury Service
Social Work Service
Surgical Service

7.3.2 Functions

A. Provide for quality and safety of the care and treatment within the service. This includes monitoring, evaluating, and improving the quality of care; patient satisfaction activities; risk management activities; patient safety; and utilization management.

B. Define important aspects of care including type and scope of services, identify indicators used to monitor quality of care**,** and evaluate actions taken.

C. Maintain records of meetings that include issues discussed, conclusions, recommendations, actions taken, and evaluation of actions taken.

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

E. Define and develop clinical privilege statements that include procedure and disease classifications.

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

7.3.3 Selection and Appointment of Medical Staff Service Chiefs

Clinical Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff and any search committee that may have been developed for a given Service. Qualifications will include certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

7.3.4 Duties and Responsibilities of Medical Staff Service Chiefs or Associate Chiefs of Staff

Each clinical service chief will be responsible to the Chief of Staff to provide effective leadership for the activities falling within his/her responsibility. Each clinical service chief is responsible and accountable for:

A. All clinically related activities of the service, including type and scope of services.

B. All administrative related activities of the service, unless otherwise provided for by the VANTHCS Director. This includes budgetary and fiscal responsibilities consistent with the policies and standards of the health care system.

C. Integration of the service into the primary functions of the organization.

D. Coordination and integration of interdepartmental and intradepartmental services.

E. Development and implementation of policies and procedures that guide and support the provision of services.

F. Recommendations for a sufficient number of qualified and competent persons to provide care/service.

G. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the service.

H. Recommending clinical privileges for each member of the service and recommending to the Organized Medical Staff the criteria for clinical privileges that are relevant to the care provided in the service.

I. Determination of the qualifications and competence of service personnel who are not licensed independent practitioners and who provide patient care services.

J. Continuous assessment and improvement of the quality and safety of care, treatments, and services provided.

K. Maintenance of appropriate quality control and quality improvement programs.

L. Orientation and continuing education of all persons in the service.

M. Recommendations for space and other resources needed by the service.

N. Recommendations for off-site sources for needed patient care services not provided by VANTHCS.

O. Monitoring of Part-time Physician time and attendance.

P. Assuring service level compliance with national and local performance measures.

Q. Assistance in obtaining and maintaining accreditation by TJC and all other applicable accrediting entities.

R. Taking reasonable measures to promote a high ethical standard of conduct and clinical competence and initiate corrective actions when necessary.

S. Assuming responsibility for and assist in the preparation of such annual reports, including budgetary planning, and other resources pertaining to the service as required by the ECMS, the Chief of Staff and/or the Director.

T. Maintaining continuing review of the professional service and performance of all practitioners in the service and prepare the required biennial review of each:

1. Assuring that his/her service participates in performance improvement activities and process measurements such as assessment and treatment of patients; medication use; use of blood and blood components; use of operative and other procedures; efficiency of clinical practice patterns; and significant departure from established patterns of clinical practice.

2. Participating in all phases of administration of that service including internal/external review activities and quality management activities; OIG and TJC visit preparation and reviews; and the creation and attainment of program goals and relevant health care system goals.

3. Participating in the Peer Review process, as defined by policy; communicate provider progress during the review period as needed for ECMS consideration of medical staff appointment.

U. Determining the qualifications and competence of service personnel who are not licensed independent practitioners.

V. Assuring that all service personnel are appropriately oriented and that they receive appropriate continuing education.

W. Assuming responsibility for enforcement of the health care system's policies, rules and regulations and of the Medical Staff Bylaws, Rules and Regulations within the service.

X. Assuming responsibility for implementation within the service of actions taken by the ECMS, as appropriate.

Y. Supervising the research, education and training programs within the service in cooperation with the person of the appropriate academic departments and the consulting and attending staffs where applicable.

Individuals at the Sam Rayburn Memorial Veterans Center, Fort Worth Outpatient Clinic, and Tyler VA Primary Care Clinic may be responsible for a portion of the above at the service level. This will depend on the level of integration of the specific service as decided by the Chief of Staff.

ARTICLE 8: EXECUTIVE COUNCIL OF THE MEDICAL STAFF (ECMS)

8.1 Composition

The ECMS consists of the following (or their designee):

Chairperson, voting:
Chief of Staff or designee (Acting Chief of Staff or Deputy Chief of Staff)

Members, voting:
Deputy Chief of Staff
ACOS for Ambulatory Care
ACOS for Education
ACOS for Geriatrics and Extended Care
ACOS for Mental Health
ACOS for Research and Development
Associate Director for Patient Care Services
Chief, Anesthesiology & Pain Management Service
Chief, Central Dental Lab
Chief, Dental Service
Chief, Medical Service
Chief, Nuclear Medicine Service
Chief, Pathology & Laboratory Medicine Service
Chief, Physical Medicine & Rehabilitation Service
Chief, Radiation Oncology Service
Chief, Radiology Service
Chief, Spinal Cord Injury Service
Chief, Surgical Service
Committee and Workgroup Chairs reporting directly to ECMS

Ex-officio, non-voting:
Director, VA North Texas Health Care System
Associate Director, VA North Texas Health Care System
Assistant Director, VA North Texas Health Care System
Assistant Director for Outpatient Services, VA North Texas Health Care System
Staff Assistant to the Chief of Staff for Operations
Staff Assistant to the Chief of Staff for Quality and Performance
Associate Director, Nursing Service

Technical Advisors, non-voting:
Chief, Clinical Quality Management Service
Chief, Human Resources Management Service
Chief, Pharmacy Service
Office of Regional Counsel
Other Affiliate Medical Staff may be called upon to serve as resources or attend committee meetings at the request of the Chairperson

A. All Medical Staff members holding service chief or associate chief of staff appointments are eligible for membership on the council. However, the council will call upon the expertise of the entire Medical Staff in its role of facilitating peer review.

B. Membership of the ECMS consists primarily of a majority of physicians, but may include other practitioners as determined by the medical staff. Medical staff members are added or removed from the ECMS through a 2/3 vote of the ECMS members.

8.2 Functions and Responsibilities

A. Act for the Medical Staff between Medical Staff meetings. This authority is delegated and defined by a 2/3 vote of the Medical Staff and the authority may be removed through a 2/3 vote of the Medical Staff.

B. Act to ensure effective communication between the Medical Staff and the VANTHCS Director;

C. Make recommendations directly to the Governing Body (VANTHCS Director) regarding the:

1. Structure of the Medical Staff.
2. Mechanisms used to review credentials and delineate clinical privileges.
3. Recommendation of individuals for Medical Staff membership.
4. Recommendation for delineating clinical privileges for each eligible individual.
5. Organization of quality management activities of the Medical Staff in collaboration with the Quality Council as well as mechanisms used to conduct, evaluate and revise such activities.
6. Mechanisms by which membership on the Medical Staff may be terminated. Any recommendations will be consistent with proposed changes to VA approved mechanisms contained in MP-5, Part II, Chapter 8 "Disciplinary Actions and Grievance Procedures".
7. Mechanisms for fair-hearing procedures that are consistent with approved VA mechanisms and proposed changes to VA approved mechanisms.
8. Medical Staff ethics and self-governance actions.
9. Review of activities to ensure compliance with all VHA and Joint Commission requirements and recommendations.
10. Receive and act on reports from medical staff committees, services, etc., as appropriate.

D. Receive action on and approve criteria for granting clinical privileges for each service. The council will meet at least quarterly and will forward minutes and recommendations to the VANTHCS Director for approval.

E. Determine professional medical policies of VANTHCS, subject to VHA and Federal regulations, recommended by reporting committees

8.3 Reporting

With the exception of credentialing and privileging matters, the ECMS will report to the Executive Leadership Board (ELB). All credentialing and privileging matters will be reported directly to the Director for final action.

8.4 Health Standards Board (HSB)

Established for the purpose of determining whether licensed providers including, but not limited to, physicians, dentists, podiatrists, psychologists, licensed clinical social workers, optometrists, chiropractors, nurses, physician assistants, expanded-function dental auxiliaries, and residents and interns, subject to the provisions of VA Handbook 5005, Part II, Chapter 3 are physically and mentally fit for appointment or retention in VA employment. For details see VANTHCS Memorandum No. 11-08 "Health Standards Board".

8.5 Peer Review – General Principles

VHA Directive 2008-004 describes the purpose of Peer Review. As stated in the Directive, "the authority for Protected Peer Review is found in Title 38 United States Code (U.S.C. 5705, entitled Confidentiality of Medical Quality-Assurance Records, and its implementing regulations. Only documents designated in advance as being developed consistent with 38 U.S.C. 5705 are confidential". VANTHCS Memorandum MS-21 outlines the procedures locally.

The Peer Review Committee, which reports regularly to the ECMS, will notify the Director immediately upon determining if the matter under review raises concerns about the possibility of substandard care, omission of care or negligence. The findings may be used as triggers to conduct a Focused Professional Practice Evaluation (i.e. management review) for non-protected purposes, such as determining the need for an adverse privileging action. Please refer to VANTHCS Memorandum No 11-03 "Focused Professional Practice Evaluation" for full process.

The processes of Quality Improvement are closely linked to the Peer Review principles. All members of the Medical Staff will participate in Quality Improvement relating to the service of which they are a member. On occasion, Peer Review may include review of cases outside of VANTHCS but which are assigned to us by the Office of Medical-Legal Affairs (OMLA) the Office of General Counsel (OGC), or from VA's within or outside our VISN via the VISN 17 Chief Medical Officer.

8.6 Committees and Workgroups that Report to ECMS

The committees and workgroups of the ECMS for VANTHCS are listed below. The policies covered by each of the committees are listed on the VANTHCS Intranet homepage for viewing or printing. Reports are given at various intervals to the members at ECMS meetings.

8.6.1 List of Committees and Workgroups

Critical Care
Geriatrics/Extended Care Operations
Health Information Management
Health Promotion and Disease Prevention
Home Respiratory Care Team
Infection Prevention and Control
Operative and Other Invasive Procedures
OR Management
Pain Management
Patient-Aligned Care Teams (PACT)
Patient Flow and Throughput
Peer Review
Pharmacy and Therapeutics (P&T)
Radiation Safety
Research and Development
Resident Supervision
Reusable Medical Equipment (RME)
Transfusion Utilization
Utilization Management

8.6.2 General Responsibilities of Committee Members

1. Committees and workgroups appointed under this Article will report and make recommendations to ECMS as outlined in individual committee charters, available on VANTHCS intranet. Timely and regular reporting of minutes and Executive Summaries to ECMS is required.
2. Committees and workgroups will meet at regular intervals and implement policies and processes that support VHA and VANTHCS.
3. Attendance and participation in work of the committee or workgroup by the respective members

8.7 Committee Records

A. All ECMS committees and workgroups prepare and maintain reports of issues discussed, conclusions, recommendations, actions taken, and evaluation of actions taken.

B. ECMS provides for appropriate and timely feedback to the Services regarding all information regarding the services and their providers.

C. ECMS and workgroup minutes are maintained with Clinical Quality Management. Individual ECMS reports from its various committees and workgroups are maintained in Clinical Quality Management Service, and the Executive Summaries are a regular part of the ECMS minutes.

8.8 Committee Attendance

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

ARTICLE 9: MEDICAL STAFF MEETINGS

9.1 General Provisions

A. The Medical Staff meets as a whole semi-annually.

B. Regular meetings are convened at the call of the Chief of Staff. Special meetings may also be convened at the call of the Chief of Staff as needed.

C. Members of the active Medical Staff are voting members.

D. Minutes of all meetings will reflect (at minimum) attendance, issues discussed, conclusions, recommendations, actions taken, and evaluation of actions taken.

9.2 Rules of the Medical Staff

The Medical Staff will adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws and guidelines of the Governing Body, subject to approval by the VANTHCS Director. Such rules will become a part of these Bylaws. Proposed amendments may be made and submitted in writing at any time to the Chief of Staff, who will coordinate and distribute them at any regular meeting of the Medical Staff at which a quorum is present without previous notice, by a 2/3 vote of those eligible to vote. Such changes will become effective when approved by VANTHCS Director.

9.3 Quorum and Voting

A quorum for purposes of Medical Staff meetings, committee meetings, and service staff meetings is defined as 50% or more of the voting membership of VANTHCS Medical Staff, the committee, or the service, respectively.

ARTICLE 10: CONFIDENTIALITY

10.1 General Provisions

Section 5705, Title 38, United States Code was enacted to protect the integrity of the VA's medical quality assurance program by making confidential and privileged certain records and documents. Disclosure of records and documents made confidential and privileged by regulations may only be made in accordance with the provisions stated therein. Disclosure of records and documents that are not confidential and privileged

by 38 U.S.C. 5705 will be governed by provisions of the Freedom of Information Act, the Privacy Act, HIPAA and/or other VA confidentiality statutes.

10.2 Breach of Confidentiality

Peer Review, review of Staff qualifications, and the evaluation of quality of care in any format provided at VANTHCS depend upon professional, open and candid, but confidential, discussions. Any breach of confidentiality of related records, discussions, or deliberations of the Medical Staff or ECMS, is considered outside appropriate standards of conduct. Breach of confidentiality will also be considered detrimental to the quality of patient care and will be subject to any adverse actions as allowed by VHA and VANTHCS policies, rules, and regulations.

ARTICLE 11: AMENDMENTS AND BIENNIAL REVIEWS

The Bylaws and Rules 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 and Rules and attendant policies may be submitted in writing to the Chief of Staff by any service chief or member of the Medical Staff. The Chief of Staff will coordinate and distribute them to the members of the Medical Staff for review. A period of not less than 15 days will be allowed for receipt of written comments from the staff on proposed amendments. No approval action may be taken on amendments to the Bylaws until the proposed amendment is considered and approved by the ECMS, either at its next regular meeting or by electronic vote. To be adopted, an amendment will then require a 2/3 vote, in a practical manner agreed upon by the members of the ECMS, of the members of the Medical Staff. This may include electronic vote by exception. Amendments so made shall be effective when approved by the VANTHCS Director.

The ECMS may provisionally adopt and the Director may provisionally approve urgent amendments to the Bylaws/Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the Medical Staff. After adoption, these urgent amendments to the Rules and Regulations will be immediately communicated back to the Medical Staff for retrospective review and comment on the provisional amendment. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article 3, Section 7 should be followed.

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

Changes are effective when approved by the VANTHCS Director.

ARTICLE 12: ADOPTION

These Bylaws, together with the appended rules, will be adopted upon recommendation of the Medical Staff at any regular or special meeting or by electronic vote by active Medical Staff at which a quorum is present. They will replace any previous Bylaws and Rules and will become effective when approved by the VANTHCS Director.

Adopted by the Medical Staff of VA North Texas Health Care System on **November 30, 2012.**

Recommended: _____
Clark R. Gregg, MD, FACP Chief of Staff

Approved: _____
Jeffery L. Milligan, Director

Rules and Regulations

I. GENERAL

A. The Rules and Regulations relate to the role and/or responsibility of members of the Medical Staff and individuals with clinical privileges in the care of inpatients (acute and long-term care), urgent care patients, home-based patients, and ambulatory care patients with different levels of acuity and needs in various settings throughout VANTHCS. Rules and regulations are issued by the Department of Veterans Affairs within the matrix of VA handbooks, manuals, directives, etc., which are elaborated in local system policy and procedures that are available to the Medical Staff. The following VANTHCS rules and regulations serve the Medical Staff to help them and guide them to provide the highest quality of medical care.

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

C. Each Medical Staff member shall be responsible for carrying out these rules and regulations to assure compliance with the standards of TJC and the rules of the Department of Veterans Affairs.

II. PATIENT RIGHTS

A. Patient Rights and Responsibilities

VANTHCS supports the rights of each patient. Specific details of these rights and of patient responsibilities can be found in VANTHCS Memorandum No. 00-01, "Patients' Rights and Responsibilities".

B. Living Will/Advance Directive/Withholding and Withdrawal of Life-Sustaining Treatment

It is the policy of VANTHCS to follow the patient's or surrogate decision maker's request to participate in health care decisions. Information on Living Wills/Advance Directives may be found in VANTHCS Memoranda Nos. 11-05, "Withholding or Withdrawal of Life Sustaining Treatment" and 122-04, "Advance Directive Documentation and Implementation". An Ethics Consult should be requested in any situation that is unclear or for which the provider needs guidance.

C. Informed Consent

1. The Medical Staff will support the right of each patient to informed consent for treatments and procedures in accordance with TJC guidelines, VA directives contained within VHA Handbook 1004.01 "VHA Informed Consent For Clinical Treatments and Procedures" and VANTHCS Memorandum No 11-04 "Informed Consent for Clinical Treatments and Procedures."

2. Informed consent should:

   a. Be consistent with legal requirements and ethical standards (e.g. potential conflict of interest where the clinician is also the researcher).

   b. Be documented in the medical record before commencement of the procedure or treatment for which it is required. See VANTHCS Memorandum No 136-30, "Authorization for Medical Record Entries & Document Completion Requirements."

3. Informed consent will be in accordance with VANTHCS Memorandum No 11-04 "Informed Consent for Clinical Treatments and Procedures". The informed consent will be completed in its entirety, i.e., including all signatures (patient, physician, and witness when applicable).

4. Submission of surgical specimens will be in accordance with the published current VANTHCS Pathology and Laboratory Medicine Service Lab Manual.

D. Adverse Event Disclosure

Information on adverse event disclosure can be found in VANTHCS Memorandum 11QC-10, "Adverse Event Disclosure".

E. Pain Management

The Medical staff will support the rights of each patient to have his/her pain screened, assessed and treated. When appropriate, a pain treatment plan is documented with adequate and appropriate interventions. and/or medication in accordance with the Department of Veterans Affairs Policy as outlined in VANTHCS Memorandum No 112A-01, "Pain Management."

F. Ethical Dilemmas

Ethics Consultation Service is available to respond to specific ethics questions or to requests for general information, policy clarification, document review, discussion of hypothetical or historical cases, or analysis of organizational ethics questions.

G. Organ/Tissue Donation

Patients or their legal next-of-kin have the right to donate organs/tissue if they choose to do so. All deaths in the hospital should be considered for possible organ/tissue donation according to the established criteria as described in VANTHCS Memorandum No 112-06 "Organ Donation and Donation of Body for Science".

H. Human Research

Patients have the right to agree to participate in research and, at the same time, they have the right to know that research requirements have been followed. VANTHCS is responsible for the protection of research subjects from undue risk and from deprivation of personal rights and dignity. This protection is best ensured by consideration of two issues, which are the touchstone of ethical research. (Reference: Program for Protection of Human Research Subjects at VANTHCS (Seventh Edition):

1. That voluntary participation by the subjects, indicated by free and documented informed consent, is ensured; and
2. That an appropriate balance exists between potential benefits of the research to the subject or to society and the risks assumed by the subject.

III. GENERAL RESPONSIBILITY FOR CARE

A. Conduct of Care

1. Management of the patient's general medical condition will be the responsibility of a qualified physician member of the Medical Staff. Licensed advanced practice registered nurses or certified physician assistants with an approved Scope of Practice will be assigned a primary physician supervisor.

2. A uniform quality of patient care will be expected of all individuals with delineated clinical privileges within and across services and among all staff members who have clinical privileges.

3. A comparable standard of quality of surgical and anesthesia care will be expected in all areas where such services are offered.

B. Emergency Services

1. VANTHCS maintains an Emergency Department under the management of the Emergency Medicine Section of Medical Service that offers emergent care services 24 hours a day. At least one physician experienced in emergency care will be on duty at all times, and specialty consultation will be available within approximately 30 minutes by members of the Medical Staff or by Residents under their supervision.

2. All ill or injured patients who come into VANTHCS for emergency medical evaluation or initial treatment will be assessed by a qualified Medical Staff member.

3. Specialty consultation in the Emergency Department is available by request of the attending Medical Staff member or by transfer to a designated hospital where definitive care can be provided.

4. Written policies and procedures specifying the scope and conduct of patient care provided by Emergency Department are maintained in the office of the Chief of Emergency Medicine Section of Medical Service.

5 Applicants without emergent/urgent medical needs or without legal eligibility for care at VHA facilities will be offered Social Work Service assistance in locating health care resources available in the community.

C. Admissions

1. General Provisions

a. Only a physician or dentist member of the Medical Staff may admit a patient to VANTHCS*.*

b. Except in an emergency, no patient will be admitted to VANTHCS until a provisional diagnosis has been entered into the medical record.

c. All inpatients will be attended by a member of the Medical Staff and will be assigned to the service or section appropriate for the treatment of the disease that necessitated hospitalization.

d. The Staff Oral and Maxillofacial Surgeon will be responsible for services rendered by the oral surgery staff. Dental or oral surgical procedures performed in the surgical suite will be under the overall supervision of the Chief, Surgical Service.

e. A patient medical history and physical examination will be completed and documented in the medical record within 24 hours of admission by the attending physician, dentist, or oral/maxillofacial surgeon, as appropriate.

f. When such history and physical examination is not recorded before the time stated for operation, the operation will be canceled or delayed unless the surgeon states in the medical record that such delay would constitute a significant hazard to the patient.

g. Bed patients admitted to Dental Service for dental procedures will receive the same basic medical appraisal as patients admitted to other clinical services. Physician members of the Medical Staff may be consulted regarding medical problems that may be present or may arise during hospitalization. Dentists are responsible for that part of their patient's history and physical examination related to dentistry.

2. Procedures

Patients will be assigned to the direct care or supervision by a Medical Staff member who is responsible for medical care and treatment, supervision of

Residents and Students, prompt completion of an accurate medical record, special instructions to the patient, and transmitting reports on the condition of the patient to the referring practitioner and family members.

3. Tests

a. Diagnostic tests will not be initiated automatically on the patient at the time of admission unless pre-determined as a Performance Measure process (such as an EKG).

b. In appropriate diagnostic situations, the Medical Staff member will obtain voluntary informed consent of the patient prior to testing as outlined in VANTHCS Memorandum No. 11-04 "Informed Consent for Clinical Treatments and Procedures".

Note: Per VHA Handbook 1004.01 Informed Consent for Clinical Treatments and Procedures, requirement for written consent for HIV testing has ceased effective August 17, 2009.

D. Areas of Restricted Admission

1. Medical Intensive Care Unit/Cardiac Intensive Care Unit (MICU/CCU)

a. The Chairman, Critical Care Committee, maintains responsibility to optimize and standardize patient care for issues relating to the MICU/CCU and SICU/TICU, including quality assurance and for issues relating to the Code Blue and Rapid Response Teams.

b. Written criteria for admission to the MICU/CCU are outlined in Medical Service Standard Operating Procedures Memorandum No. 111-23 (Policies of the Coronary Care/Medical Intensive Care Unit).

c. Multi-system failure will be managed by the primary cardiovascular or pulmonary services. Other medical subspecialties may be consulted as appropriate to assist in patient management.

d. The Director, MICU, and the Director, CCU, are responsible for administrative issues relating to non-cardiac and cardiac issues, respectively.

2. Surgical Intensive Care Unit/Thoracic Intensive Care Unit (SICU/TICU)

a. Written criteria for admission to the SICU/TICU are outlined in "Discharge Guidelines for patients admitted to the Surgical Intensive Care Units (SICU's) at VANTHCS".

b. Consultation with the attending intensivist and/or the ICU resident on call (under the supervision of a staff physician) is required when patients are

admitted to the SICU. The General Surgery Chief Resident or Cardiothoracic Fellow will help triage patients to be discharged to the floor whenever there are no ICU beds available. The General Surgery Chief Resident and the Cardiothoracic Fellow will follow the patient in their respective units until the patient is transferred out.

c. All critically ill patients are under the joint care and management of the intensive care team and the unit/admitting team. Appropriate consultations with other services (Cardiology, Neurology, Pulmonary, Renal, etc.) may be requested.

d. The Directors of the SICU and TICU maintain ultimate administrative responsibility for issues relating to the SICU/TICU.

E. Transfers

1. Policies and procedures governing the transfer of patients to and from the MICU/CCU and SICU/TICU are outlined in VANTHCS Memorandum No. 136-08 (Interfacility Transfer Policy), Medical Service Standard Operating Procedure Memorandum No. 111-23 (Policies of the Coronary Care/Medical Intensive Care Unit), and “Discharge Guidelines for patients admitted to the Surgical Intensive Care Units (SICU’s) at VANTHCS” respectively.

2. Transfer of a patient to VANTHCS from another health care facility is usually arranged in order to obtain continued or specialized treatment. Under no circumstances will a patient be accepted for transfer until the referring physician has discussed the patient’s care with the accepting staff physician and an agreement has been reached to accept the patient at that time. There must be agreement that the patient is identified as "stable" for transport. Judgment will be exercised to meet the medical needs of the patient during transfer.

3. When a patient is accepted for transfer, the accepting and transferring physician or their designee should agree on and record specific information on VA Form 10-2649A, Interfacility Transfer Form, and VA Form 10-2649B, Patient Consent to Transfer. Both forms will be filed in the medical record.

4. Per VHA directive, transport is the responsibility of the sending hospital. Transfers will not be made at VA expense merely to comply with the wishes of a patient, a family member or other interested person, except as stated in subparagraph 5 below.

5. A hospitalized patient who develops a need for treatment that VANTHCS is not staffed or equipped to provide may be transferred to another VA medical center or to a non-VA hospital that has adequate facilities and staff. Preference will be given to using another Federal Government facility or a non-VA hospital with which VANTHCS has entered into a sharing agreement. Transfer to a non-VA hospital is restricted to those VA beneficiaries

developing a bona fide medical emergency that precludes moving the patient to another VA medical center or other Federal Government facility. Patients transferred to non-VA hospitals in accordance with the provisions of M-1, Part I, Chapter II will be returned as soon as practicable to VANTHCS to recover.

6. Patients transferred to another VA facility may be returned to VANTHCS for continued care when medically indicated. VANTHCS will provide a bed for the return of a transferred patient when mutually agreeable between the facilities involved and when the best interest of the patient will be served.

7. A veteran with a terminal illness and a probable life expectancy of limited duration (weeks or months) who requires continuing hospital or nursing home care, may be transferred to a suitable VA medical center nearer the veteran's home. Transportation for such transfers will be at VA expense if the veteran meets the basic eligibility criteria as provided in M-1, Part I, Chapter II for payment or reimbursement of beneficiary travel expense.

8. The patient's Medical Staff attending physician will determine and document the need for any special care to be provided during transfer. If possible, travel arrangements will be made to permit arrival at VANTHCS during the regular administrative workday prior to 2:00 p.m.

9. When a transfer patient is escorted by a VA employee or authorized attendant, copies of the consolidated health record and diagnostic images will be placed in the custody of the escort to accompany the patient. If the patient is required to transport medical records, these will be transported in a locked bag. When a transfer patient is not to be escorted, the records and x-rays will be mailed or sent by courier service to the receiving facility to arrive before the patient. If the patient is likely to arrive at the receiving facility before the records, appropriate identification and treatment information will be telephoned or faxed in advance. Rules for protection of private patient information will be followed.

10. Transportation that is to be at government expense must be coordinated through the Travel Office during regular hours. After regular working hours transfers will go through the ER physician, who must medically justify the need for transport. The AOD and Bed Control staff must be integrally involved to assure a smooth transfer.

F. Consultations

1. Required Consultations:

Except in an emergency, consultation with another qualified physician is required when the patient's physician or dentist judges that:

a. A patient's condition warrants a medical risk assessment prior to

consideration for an operation, invasive procedure, or medical treatment.

b. The diagnosis is obscure.

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

2. Consultant:

A consultant must be well qualified to give an opinion in the field of his/her specialization. The qualifications and privileges of the consultant are determined by the Medical Staff on the basis of an individual's training, experience, and demonstrated competence.

3. Essentials of a Consultation:

A satisfactory consultation includes review of the medical record and examination of the patient by the attending physician. An opinion signed by the consultant must be included in the medical record within 24 hours. When operative procedures are involved, the consultation note, except in an emergency, will be recorded and signed prior to the operation.

4. Responsibility for Requesting and Furnishing Consultations:

The patient's physician or dentist shall be responsible for requesting consultation. The chief of service will ensure that all requests to his/her service for consultation are answered timely.

G. Discharge Planning

1. Discharge planning is an ongoing, interdisciplinary process beginning prior to admission for scheduled admissions and at the time of admission for unscheduled (urgent or emergent) admissions. The processes involved in the facility's discharge planning policy are described in VANTHCS Memorandum No. 139-02 "Discharge Policy"

   a. Patients who do not have serious or chronic illness and who have a good social support system and adequate financial resources will usually manage their own discharge planning and will not require a physician's referral of the case to Social Work Service.

   b. Some patients, in adjusting to the effects of illness, will have family, financial, health compliance, or other problems. These patients should be identified by the physician and referred to Social Work Service as soon as possible. This will ensure that discharge planning is not delayed or compromised.

   c. A significant number of patients are "high risk" because they present complex discharge and aftercare problems. They may have chronic or

life-threatening illnesses; histories of multiple admissions; or inadequate financial, housing, or relationship resources. It is important that the physician identify these patients as quickly as possible so that the intricacies of discharge planning can be addressed as rapidly and energetically as possible well prior to anticipated discharge. High risk factors may include:

Age 80 or older
AIDS/HIV positive
Homelessness
Loss of caretaker
Recurrent or metastatic malignancy
Suicide attempt
Readmission within seven days of discharge
Heart failure

d. Patients not deemed "high risk", who have a good prognosis and good social support systems, will not usually require social work services. A social worker will be available if the patient's condition or situation deteriorates. In such cases, Social Work Service will develop and coordinate a plan in consultation with the interdisciplinary team caring for the patient.

2. Nursing staff will initiate discharge planning at the time of admission, and will follow physician's discharge instructions. If home health care is anticipated, the physician will submit a Geriatrics and Extended Care (GEC) or hospice/palliative care referral as early in the hospitalization as possible to allow timely processing.

3. Physicians, nurses, case managers, social workers, dietitians, chaplains, psychologists, audiologists, speech pathologists, and rehabilitation services staff are available to meet patient needs. Referral to the OEF-OIF-OND Program Coordinator will be made for all eligible veterans. Applicable Clinical Reminders will be completed prior to discharge.

4. Discharge will be documented in the medical record with a discharge summary on the day of discharge with the exception of the community living center (CLC). Discharge from the CLC will be documented in the medical record within three days of discharge.

H. Discharge

1. General Provisions for Discharge from Hospital

a. Patients will be discharged only on a written order of the physician or dentist. As per VANTHCS Memorandum No. 139-02 "Discharge Policy" patients discharged from VANTHCS also require, as appropriate, orders for referrals, transportation, equipment, supplies (including home oxygen),

medication, follow-up appointments, medication reconciliation, etc.

b. Physician/Dentist Discharge Orders are completed in the Computerized Patient Record System (CPRS). The physician/dentist electronic signature activates the CPRS discharge orders. Discharge medication prescriptions, prosthetic requests, and requests for travel are activated through CPRS, and requests are filled when discharge orders are released. Delayed CPRS orders will not be activated until released by the physician/dentist. The Clerk and/or Nursing staff are responsible for verifying all orders written by the physician in CPRS by placing their initials into the appropriate CPRS header. The Clerk schedules routine primary care follow-up appointments. Referrals to specialty clinics require a CPRS consult to the appropriate clinical specialty by the physician/dentist.

c. Patients who are dependent upon home nursing or other assistance will not be discharged until it is ensured that their care outside of VANTHCS will be adequate.

2. MICU/CCU:

Discharge from the MICU/CCU to a lower level of care or to home will be considered based on the MICU/CCU discharge criteria (updated yearly). Discharge criteria are only guidelines for discharge. An attending Intensivist may discharge patients he/she deems appropriate for discharge.

3. Post-anesthesia Care Unit (PACU):

Discharge from the PACU for patients post general anesthesia, regional anesthesia, or Monitored Anesthesia Care (MAC) typically will be based on the "Post Anesthesia Care Unit Policy and Procedure Manual PACU Discharge Criteria". These criteria may be modified depending on the individual patient. "Discharge" refers to patient relocation to a less intensive setting, e.g., regular nursing unit. Patients not meeting discharge criteria after an appropriate stay in PACU, or when indicated, will be relocated to an ICU area. Discharge criteria are only guidelines for discharge. An attending Anesthesiologist may discharge patients he/she deems appropriate for discharge to the appropriate unit.

4. Surgical Intensive Care Unit (SICU)/Thoracic Intensive Care Unit (TICU):

Discharge from the SICU/TICU will be typically based on consideration of the SICU/TICU "Discharge Guidelines for patients admitted to the Surgical Intensive Care Units (SICU's) at VANTHCS". Discharge criteria are only guidelines for discharge. An attending Intensivist may discharge patients he/she deems appropriate for discharge.

5. Against Medical Advice:

Should a patient leave against medical advice, this will be documented in the medical record and the patient will be requested to sign the appropriate document.

I. Patient Death: In the event of death, the patient will be pronounced dead by a licensed physician or specially trained Registered Nurse (Long Term Care). The body will not be released until there is an appropriate medical record entry by a licensed physician. Policies with respect to the release of a patient's body will conform to VHA, Federal, and Texas State regulation.

J. Autopsy

1. General Provisions:

In the interest of improving patient care and professional knowledge, every member of the professional staff is expected to actively participate in securing permission for autopsies in all deaths. Special effort will be made to secure an autopsy in accordance with the criteria noted in VANTHCS Memorandum No. 113-06, "Post Mortem Examinations". Autopsies will be performed only by Pathology and Laboratory Medicine Service (P&LMS) staff.

2. Consent for Autopsy:

Consent for autopsies will be obtained by signature of the legal next-of-kin or authorized representative (e.g. power of attorney) on the appropriate form, including any limitation on the scope of the autopsy imposed by the next-of-kin or authorized representative.

3. Request for Autopsy:

The physician staff will provide information regarding clinical diagnosis and concerns to the P&LMS staff prior to the autopsy, specifically including any infection hazards. Request for autopsy will be fulfilled as soon as the following requirements are met:

a. The hospital death does not constitute a County Medical Examiner's Case. See VANTHCS Memorandum No. 113-06, "Post Mortem Examinations".

b. If the death is a County Medical Examiner's Case, it has been reported by a physician and released by the Medical Examiner's office with a "No Case" or "Form-16" number recorded in the CPRS note and on the consent form.

c. Authorization for autopsy, SF-523, is completed and bears the signature of the next-of-kin or authorized representative (e.g. power of attorney), the

physician, and two medical center employee witnesses. See VANTHCS Memorandum No. 113-06, "Post Mortem Examinations".

d. Autopsies are performed between the hours of 8:00 a.m. and 3:00 p.m., Monday - Saturday and on an emergency basis on Sundays, holidays or after hours if necessary, in consultation with the pathologist on call. Autopsies authorized after 3:00 p.m. are performed the next morning.

K. Surgical and Cytology Specimens

1. All tissue, including teeth and foreign bodies, or other specimens removed from patients will be referred to P&LMS for processing and examination.

2. Surgical and cytology specimens will be examined and diagnostic reports issued of the findings upon accurate completion of a Tissue Examination Form (SF 515) that should accompany every appropriately labeled specimen.

3. Tissue diagnoses from surgical and cytology specimens will be used as a source of clinical information in quality assessment and management activities.

4. VA pathologists must review and issue a report on the slides or other pathologic materials for all surgical or cytology specimens obtained outside VA that are used as a basis for treatment or surgery.

IV. PHYSICIAN ORDERS

A. General Requirements

1. All physician, podiatrist, chiropractor, or dentist orders for diagnostic, therapeutic, or medication interventions must be entered directly into CPRS.

2. Treatment orders will be entered and signed only by active, associate, House Staff, and affiliate Medical Staff members within the authority of their clinical privileges or scope of practice as appropriate.

B. Medication Orders

1. All medication orders, with the exception noted below, must be electronically entered into CPRS and must include date, time, medication, dose, route, timing of administration, and signature of the physician/prescriber. Schedule II narcotic controlled substances for outpatient use will be hand written on VA Form 10-2577F. Medication orders written by Physician Assistants, APRNs, CRNAs or Clinical Pharmacists with proper authorization must be co-signed within 24 hours by a provider licensed to prescribe medications, unless co-signature is not required under the relevant scope of practice. All medication regimens and orders will be in accordance with VANTHCS Memorandum No

119-01, "Drug Policy and Procedures".

2. Personal Medications:

Medications brought to VANTHCS by a patient and kept in VANTHCS after the patient is admitted will be sent to Pharmacy Service for safe-keeping or destruction. See VANTHCS Memorandum No. 119-10, "Disposition of Drugs Brought to the Medical Center by Patients upon Admission", for additional information.

3. Bedside Medications:

a. Medications are authorized for bedside use only for Self Medication programs approved by the Pharmacy and Therapeutics Committee when ordered by the responsible physician.

b. Labels for bedside medications are required as follows:

1. The manufacturer's label is adequate on over-the-counter (OTC) drugs.

2. All other bedside medications must be ordered by the prescriber indicating "for bedside use" and entered directly into CPRS. The label on the medication should be processed by the Pharmacy.

c. Bedside medications will be limited to a maximum quantity of seven days' dosing. Prescriptions for the Mental Health self-medication program may be refilled up to three times.

4. Prescription Forms:

Prescription orders will be entered directly into CPRS VA Form 10-2577F, Security Prescription Form, or VA Form 10-1158, Doctor's Orders may be used for all other prescriptions only when the provider does not have computer access or while CPRS is not available. All medications, general medical supplies, and outpatient pharmacy-related prosthetic devices/supplies for specific patient use will be ordered in this manner. *Exception: all outpatient Schedule II narcotics require a hard copy VA Form 10-2577F.* VANTHCS Memorandum No. 119-16, "Control of VA Form 10-2557F, Prescription Forms" covers all procedures related to this topic.

C. Automatic Stop Orders

Guidelines for Automatic Stop Orders are outlined in VANTHCS Memorandum No.119.01, "Drug Policy and Procedures"

D. Verbal or Telephone Orders

Verbal and telephone orders are used only in cases of emergent or urgent

situations in which evaluation or treatment of clinical situations must be addressed promptly but in which the provider does not have ready access to CPRS. This process must follow TJC "write down, read back" methodology, although, in some emergent situations, a verbal "repeat back" is acceptable. Verbal or telephone orders for diagnostic or therapeutic interventions may be accepted by a Registered Nurse (RN), Certified Respiratory Therapy Technician (CRTT), or Clinical Pharmacy Specialist (CPS). The order will include date, time, name of the ordering physician and full name and title of the RN, CRTT, or CPS. Full procedural guidelines can be found in VANTHCS Memorandum No. 118A-10, "Verbal and Telephone Orders". Orders for Total Parenteral Nutrition (TPN), Chemotherapy, and DO NOT RESUSCITATE (DNR) cannot be accepted verbally or by telephone.

E. Order Sets

Collections of orders that facilitate a specific patient care activity. will be approved individually by the respective clinical service chiefs. Each component order will be displayed in CPRS for review and signature by the ordering clinician. Order sets will be revised as appropriate by each service.

F. Investigational Drugs

An investigational drug for clinical use is one for which a sponsor has filed and has approval for an investigational new drug (IND) application with the Food and Drug Administration. Use of an IND in clinical research must be conducted according to a protocol approved by the Institutional Review Board (IRB) and the Research and Development Committee (RDC) of VANTHCS. The wisdom and sound professional judgment of the investigator, the staff, and the Research and Development Committee collectively will determine what constitute the rights and welfare of human subjects in research and what constitute risks and potential medical benefits of the use of a particular drug and/or investigational device or procedure. Necessary for consideration of a protocol by the RDC are the protocol of the study; a Lay Summary and Consent Form (VA Form 10-1086) specific to the study; a copy of VA Form 10-1086, Agreement to Participate in Research by or Under the Direction of the Department of Veterans Affairs, indicating the title of the study and signed by the investigator; and VA Form 10-9012, Investigational Drug Information Record, for each drug in the study. Additional information on the use of investigational drugs may be found in VANTHCS Memorandum No. 151-01, "Investigational Drugs".

G. Informed Consent

Information on informed consent may be found in VANTHCS Memorandum No. 11-04 "Informed Consent for Clinical Treatments and Procedures".

H. Submission of Surgical Specimens - All tissue (including teeth) and foreign bodies removed in the Operating Room or other clinical unit will be sent to P&LMS for examination and specific processing considered necessary to arrive

at a pathological diagnosis.

I. Special Treatment Procedures

1. **Do Not Resuscitate (DNR) Orders:** This policy is outlined in VANTHCS Memorandum No. 11-06, "Do Not Resuscitate (DNR) Orders".

2. **Advance Directive:** This policy is outlined in VANTHCS Memorandum No. 122-04 "Advance Directive Documentation and Implementation".

3. **Withholding or Withdrawal of Life-Sustaining Treatment:** This policy is outlined in VANTHCS Memorandum No. 11-05, "Withholding or Withdrawal of Life Sustaining Treatment".

4. **Physical Restraint and Seclusion** - This policy is outlined in VANTHCS Memorandum No. 118A-11, "Physical Restraint and Seclusion".

5. **Emergency Detention and Court Ordered Treatment**

   a. The Medical Staff will comply with the Mental Health Code of the State of Texas in matters of court-ordered treatment and emergency detention of patients.

   b. VANTHCS is capable of providing care for patients under a court order for Mental Health Treatment. However, VANTHCS is not able to accept patients brought to the facility for emergency detention under a Mental Illness Warrant.

   c. Patients requiring court ordered treatment are processed through the Dallas County Mental Illness Court**.**

   d. The ACOS for Mental Health is responsible for coordinating activities relating to court-ordered mental health treatment.

6. Impaired Mentation: Patients under the Influence of Drugs or Alcohol

   a. A person presenting to the Emergency Department apparently under the influence of drugs or alcohol will be evaluated for the presenting complaint. If a medical problem exists, that problem will be treated appropriately.

   b. If the person becomes combative, he/she will be restrained, if necessary, to prevent injury. Side rails should be up at all times.

   c. If the patient is combative, procedures found in VANTHCS Memorandum No. 116B-04 "Violent Behavior Prevention Program" will be followed. Emergency Department personnel should be cautious about making diagnostic assumptions about intoxicated patients. When possible, all

patients under the influence of drugs or alcohol should be put in a gown in order to facilitate a complete physical examination.

d. If an intoxicated patient is discharged from the Emergency Department, or leaves against medical advice (AMA), and Emergency Department personnel perceive a probability of imminent physical injury to the patient, or to others, the patient should be released only to a responsible adult friend or family member who agrees to drive the patient home and keep him/her under observation. If no responsible parties are available, law enforcement personnel should be notified of the imminent danger in order to check or restrain the patient. Special consideration should be given to holding the patient in the ED for observation, when possible, if unable to find someone to whom the patient can be released.

e. Alcohol addicted patients will be referred to Mental Health Triage.

f. Drug addicted patients will be referred to:

1. Mental Health Triage, or
2. Greater Dallas Council on Alcohol and Drug Abuse

g. If the physician believes it would be dangerous for an incompetent patient to leave the Emergency Department, a request can be made for the psychiatrist on call to reevaluate the patient.

7. Patients with Suicidal Ideation: This policy is outlined in VANTHCS Memorandum No. 116A-01, "Suicide Prevention, Assessment, and Management".

V. SUPERVISION OF TRAINEES (HOUSE STAFF, RESIDENTS, AND NON-PHYSICIANS)

A. Supervision of Resident Physicians/Dentists

1. For VANTHCS policy and complete procedures on Resident Supervision, see VANTHCS Memorandum No. 141-02, "Resident Supervision".

2. Medical Staff members who choose not to participate in the teaching program will not be subject to denial or limitation of privileges for this reason alone.

B. Supervision of Non-Physician/Dentist Members of the Medical Staff are supervised as follows:

1. **Psychologists** - All staff psychologists will operate within the scope of their clinical privileges as independent practitioners. All staff psychologists practice under the professional supervision of the Chief, Psychology Section of Mental Health Service.

2. **Podiatrists** - Podiatrists will operate within the scope of their clinical privileges as independent practitioners under the administrative and clinical supervision of the ACOS for Ambulatory Care.

3. **Physician Assistants (PAs)** - Physician Assistants will:

   a. Exercise judgment within their clinical scope of practice, providing that a physician member of the Medical Staff will have ultimate responsibility for their patients' care. Each PA will have one or more designated physician supervisor, either physically present in VANTHCS (or its satellites), immediately available for telephone consultation, or available to be physically present within 15 minutes.

   b. Participate in the management of patients under the supervision or direction of one or more physician supervisor(s).

   c. Within the limits established by the Medical Staff and consistent with the State Practice Acts and VA regulations, write orders and record reports and progress notes in patient medical records.

   d. Be assigned individually to an appropriate clinical service and will carry out their activities subject to service policies and procedures and in conformity with a clinical scope of practice and the applicable provisions of the Medical Staff Bylaws and Rules. Refer to VANTHCS Memorandum No. 11C-04, "Physician Assistants Scope of Practice" regarding scopes of practice and VANTHCS Memorandum No.119-01, "Drug Policy and Procedures" regarding medication usage and orders.

4. Advanced Practice Registered Nurses (APRN) - Nurse Practitioners, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists (CRNA's)

   a. APRNs will operate under the guidelines of the Affiliated Medical Staff definitions, paragraph D of these Bylaws and VANTHCS Memorandum No. 118A-16, "Guidelines for Advanced Practice Nurses".

   b. CRNA's - In exercising their professional responsibilities for individual patients, CRNA's are responsible to a staff anesthesiologist who is in turn responsible to the Chief, Anesthesiology & Pain Management Service.

5. Clinical Pharmacy Specialists (CPS)

CPS will operate under the guidelines of the Affiliate Medical Staff definitions, paragraph D of these Bylaws.

VI. MEDICAL RECORDS

A. Basic Administrative Requirements

1. Content - All entries made to the medical record will be intelligible, dated, and authenticated with an electronic signature.

2. Confidentiality - All Medical Staff will abide by VANTHCS Memoranda Nos. 04D-01, "Release of Information" and 00-16, "Privacy Policy" regarding Release of Information and Privacy. HIPAA guidelines will be followed at all times.

3. Clinical encounters are defined by VHA Directive 2009-002. All encounters requiring clinical notes and encounter forms will be completed within 1 calendar day to ensure patient safety and continuity of care. Exceptions will include official travel and unanticipated absences (sick leave, emergency leave, etc.). Supervisors may also grant extensions for annual leave and periods affected by CPRS downtimes, as appropriate. Extensions allowing completion in more than 3 calendar days are strongly discouraged from a patient safety and continuity of care perspective.

4. The Computerized Patient Medical Record System (CPRS) is the official medical record. All primary means of documentation is required to be in CPRS.

B. Responsibility of Medical Staff for Authentication

1. Authentication of a medical record entry is the responsibility of the medical provider making the entry and should be done as soon after the preparation or completion of the entry as possible.

2. Residents or other individuals (House Staff) not permitted to provide services independently will have patient History and Physicals and Discharge Summaries countersigned by the responsible supervising attending Medical Staff member. An Attending Admission note, per VHA Handbook 1400.1 Resident Supervision, is also required.

3. Staff physicians will also enter periodic notes in the patient's medical record, or at a minimum, countersign the resident's notes verifying concurrence with diagnoses and management.

4. No Medical Staff member will be required to authenticate entries that are not the staff member's own.

C. Symbols and Abbreviations

1. Symbols and abbreviations may be used in the medical records only when they have been approved by the Health Information Management Committee

and have final approval from Clinical Quality Management.

2. Symbols and abbreviations will not be used when documenting in the Discharge Summary final diagnoses, complications or operative procedures on patients released from inpatient and ambulatory/outpatient services.

D. Release of Information (ROI)

1. Information from a medical record will be released to an outside entity only with the signed Release of Information (VA Form 10-5345) of the patient or person authorized to act for the patient.

2. All requests involving release of information will be forwarded to Medical Administration Service (MAS). Oversight is by the Privacy Officer, and all ROI requests must comply with HIPAA guidelines as well as VANTHCS Memoranda 136-04 and 136-06 as noted above under Basic Administrative Requirements (A.2).

E. Timeframes for Completion of Records

1. Medical Records should be completed within 30 days of release of the patient from inpatient care.

2. A medical record is considered complete only when it contains:

   a. Authenticated History and Physical Examination
   b. All Authenticated Operative Reports from that admission
   c. Authenticated Doctor's Orders
   d. Authenticated Discharge Summary
   e. Coding and entering into Patient Treatment File (PTF)

3. A 30-day workday period is permitted for completion of a routine autopsy. (Refer to VANTHCS Memorandum No. 136-16, "Post Mortem Examinations").

4. Documentation of emergency care should be completed by the end of that shift and signed off to ensure it is visible to other caretakers.

F. Basic Requirements for Content of the Medical Record

1. Patient identification (name, address, SSN, DOB, telephone contact next of kin)

2. Medical History and Physical Examination, including history and details of present illness/injury

3. Observations, including results of therapy, documented in Progress Notes

4. Diagnostic and therapeutic orders

5. Reports of procedures, tests, and their results

6. Progress notes by physicians, nurses, and ancillary care staff, as indicated

7. Consultation reports

8. Informed consent before procedures or treatments are undertaken and, if not obtained, documentation of the reason

9. Documented Universal Protocol ("Time Out") before procedures are started

10. Documentation of patient education

11. Allergies

12. Advance Directive/DNR

G. Inpatient Medical Records

1. History and Physical Examination (H&P)

   a. History (relevant to past, social, family, military, and occupational) and Physical Examination will be performed and documented for each patient within 24 hours of admission. H&P entered by a resident physician will be cosigned by an attending medical staff member within 24 hours of admission.

   b. For patients admitted primarily for dental diagnoses and treatment, a history and clinical evaluation of the dental/oral problem will be completed by the admitting dentist.

   c. If a patient is readmitted within 30 days following the date of discharge for the same or a related condition, an Interval History and Physical Examination reflecting any subsequent changes may be used in the medical record. When used, an Interval H&P will be entered on a Progress Note and contain the following:

      1) A statement that the previous H&P examination has been reviewed and/or

      2) A statement about pertinent additions to the history and/or subsequent changes in the physical findings, or a statement indicating there is no change noted in the review of the previous H&P examination.

   d. H&P's written by PAs and APRNs will not require co-signature by the attending physician unless otherwise specified in the individual's scope of practice.

2. Initial Assessment

   a. The medical records of all patients will contain a documented statement of the treatment plan, which may appear at the conclusion of the H&P. Medication Reconciliation will be accomplished through comparing the patient's preadmission medication ("Home List") with the medications which will be provided to the patient during hospitalization. See VANTHCS Memorandum No. 119-04, "Accurate and Complete Reconciliation of Medications Across the Continuum of Care"

   b. This statement will be based upon the outcome of the initial assessment of the patient and will include those diagnostic/therapeutic procedures and/or activities planned to restore the patient to a maximum level of health and social function, and, as appropriate, employment.

3. Progress Notes

   As required by TJC standards, patient records will contain the following, as appropriate, in the Progress Notes:

   a. Admission note
   b. Inter-service Transfer notes
   c. Preanesthetic and preoperative notes
   d. Operative and/or procedure reports
   e. Postanesthetic and postoperative notes
   f. Withholding or withdrawal of life-sustaining procedures or Advance Directive notes
   g. Seclusion and/or restraint notes
   h. Discharge and/or patient instruction note
   i. Documentation of medication reconciliation
   j. A progress note with justification is required for a patient who is granted pass or leave privileges.
   k. Specific progress notes will be recorded, as appropriate, to conform with existing directives:

      1) Note regarding oral consent for performance of certain procedures
      2) Note of medical problems requiring emergency identification
      3) Note pertaining to the testamentary capacity of the patient
      4) Note documenting verbal informed consent for performance of dental operations and other procedures
      5) Social Work Service closing summary
      6) Dental Summary

4. Doctor's Orders

   a. All doctor's orders will be timed and in accordance with TJC Standards and VHA regulations.

b. Removal of a patient from suicidal observation will be made only with the approval of a Mental Health staff physician or the ACOS for Mental Health Service.

c. Do Not Resuscitate (DNR) orders will be documented only by a staff physician and may not be entered verbally or by telephone order.

d. If an Advance Directive (AD) is on file in the patient record or electronic record, the physician primarily responsible for the patient will document the existence and scope of the AD in the Progress Notes.

5. Informed Consent

a. Medical records must document the performance of treatments and procedures requiring informed consent, as outlined in VANTHCS Memorandum No. 11-04 "Informed Consent for Clinical Treatment and Procedures".

b. Treatments or procedures that involve experimental protocols, the use of investigational drugs or research have special informed consent requirements; see M-3, Part I, Chapter 9.

6. Discharge Summary

a. A Discharge Summary is prepared for all releases from hospital, domiciliary and transitional care, including deaths and transfers to other levels of care such as VA Domiciliary care, VA CLC, other VA medical centers, and non-VA medical centers. See VANTHCS Memorandum 136-03, "Hospital Summary" for details.

b. The discharge summary will be dictated on or before the day of discharge and will include at least:

1) Reason for admission
2) Findings
3) Treatment given
4) Procedures performed
5) Condition on discharge
6) Pertinent discharge instructions
7) A reconciled list of medications which is comprised from a review of the admission medications and the discharge medications. A copy of this list will be provided to the patient and will be available to the after-hospitalization provider through CPRS or by hard copy. Please refer to VANTHCS Memorandum No. 119-04, "Accurate and Complete Reconciliation of Medications Across the Continuum of Care" for the full guidelines on medication reconciliation.
8) Arrangements for post-hospital care

c. Responsibility for the preparation of the discharge summary and its content rests with the member of the Medical Staff having primary care responsibility for the patient. Where primary care is being rendered by House Staff, the attending physician will assure appropriate and timely preparation of the summary and authenticate it with co-signature in CPRS.

d. No set standard of length of a discharge summary is prescribed, but the responsible Medical Staff member should exercise judgment and present essential pertinent information as clearly and concisely as possible.

e. Dentist members of the Medical Staff shall prepare and sign a Discharge Summary for those patients admitted primarily for dental diagnoses and treatment.

H. Outpatient Medical Records

1. Patient Problem List

a. The record of each patient on ambulatory and/or outpatient status who has three or more visits within a six month period at a VA facility will include a list of known significant diagnoses, conditions, procedures, drug allergies and current medications.

b. Entries other than diagnoses, if significant, for the information of the health care team, may be recorded on the Problem List.

c. The Problem List will be initiated by the third outpatient and/or ambulatory care visit to the health care provider and updated as necessary upon subsequent outpatient and/or ambulatory care visits.

d. Attempted suicide will be documented on the Problem List.

2. History and Physical Examination

a. When a patient is admitted to VA care at an ambulatory and/or outpatient care level, a relevant history of the illness or injury and physical findings will be documented in the patient record.

b. When a patient is placed in an outpatient program following an episode of inpatient care, the initial note will reflect an assessment or statement of the condition(s) for which that care is being provided.

c. Special protocols as prescribed into current directives will be followed for certain other patients such as OEF-OIF-OND veterans, Gulf War veterans, former POWs, and those who claim exposure to nuclear tests, ionizing radiation, Agent Orange, or environmental contaminants.

d. The results of examinations required by protocol will be in CPRS. These records may include Compensation and Pension Examination records in cases in which the veteran is not now and has not been a patient.

e. H&P's written by PAs and APRNs will not require co-signature by the attending physician, unless otherwise specified in the individual's scope of practice.

3. Treatment Plan

a. A statement of the planned treatment will be documented for all other ambulatory/outpatients following the initial assessment and whenever a change in treatment is indicated.

b. A treatment plan will be documented for each Home Based Primary Care (HBPC) patient and Spinal Cord Injury home care patient which will describe those services and activities required and the treatment objectives.

c. Medication Reconciliation – As noted in the section above on Inpatient Medical Records (section 6. b., VANTHCS Memorandum No. 119-04 "Accurate and Complete Reconciliation of Medications Across the Continuum of Care" provides guidance on Medication Reconciliation procedures.

4. Progress Notes - General

a. A pertinent progress note will document each ambulatory/outpatient care visit. The quality of the notes will be similar to that of inpatient notes.

b. Progress Notes should contain sufficient information to:

1. Identify the patient
2. Support the diagnosis
3. Justify the treatment
4. Document the course and results
5. Facilitate continuity of care

c. Notations concerning broken appointments or termination of treatment will be made in the Progress Notes.

d. Vital signs will be documented at the time of the H&P as well as during interval outpatient visits.

5. Progress Notes - Mental Health - Outpatient with more than two visits a week

a. Each visit will be documented in CPRS
b. Any significant change noted in the patient's condition during the visit will

be documented with a brief note.
c. A summary of the patient's participation will be documented monthly.

6. Progress Notes – Ambulatory Surgery: The medical record thoroughly documents operative or other procedures and the use of anesthesia or moderate sedation, and includes documentation of Universal Protocol.

7. Doctor's Orders - Doctor's orders will be entered into CPRS.

8. Informed Consent: Documentation of informed consent will be made a part of the ambulatory/outpatient care record prior to surgery or any other procedure requiring informed consent. See VANTHCS Memorandum No. 11-04, "Informed Consent for Clinical Treatments and Procedures"

I. Emergency Care Records

1. The qualitative standards for recording data on periods of emergency care will be equivalent to those for inpatient hospital care. Every precaution will be taken to have a complete record that is adequate for medical/legal purposes.

2. When emergent, urgent, or immediate care is provided, documentation will include:

   a. Time and means of arrival
   b. Brief H&P
   c. Diagnostic testing performed
   d. Treatment rendered
   e. Diagnosis
   f. Final disposition
   g. Condition at discharge
   h. Medication Reconciliation
   i. Instructions for follow-up care
   j. Notation if patient left against medical advice

3. Urgent or emergent care rendered for humanitarian reasons to a person who is not admitted and/or who is not eligible for care at VANTHCS will be documented in a patient record. Urgent or emergent care information will be incorporated into an existing patient record whenever one exists.

J. Operating Room Records

1. Pre-Anesthetic Risk Assessment

   a. A Staff Anesthesiologist or member of the anesthesia care team (Staff Anesthesiologist and Nurse Anesthetist, Physician Assistant, or Anesthesia Resident) will perform a Pre-Anesthetic Risk Assessment on patients scheduled to have any procedure requiring anesthesia service. Information obtained will be recorded electronically or on a pre-anesthesia

evaluation chart using VA Form 10-585 (549) “DVAMC Anesthesia Record” (hardcopy). This information will be collected before the procedure

b. Patient name, complete identification number, age, gender, height, weight, allergies, baseline vital signs, past medical history, physical examinations, current medications, past surgical interventions, and complications of previous anesthetic experiences should be recorded. Information required to complement this evaluation includes results of any preoperative workup (laboratory, diagnostic imaging, EKG, other pertinent invasive or non-invasive studies) and consultations by other services.

c. A Staff Anesthesiologist will determine the necessary pre-operative tests required to adequately assess the risk of a patient’s undergoing anesthesia for the procedure. Appropriate medical consultation will be sought for individual patients when indicated. A risk classification status will be designated according to American Society of Anesthesiologists (ASA) Guidelines.

d. Patients or their representatives will be informed about alternatives to anesthesia and anesthetic preoperative risks except in extraordinary situations in which the patient requires emergency surgery, is incapable of giving informed consent and a representative cannot be reached. A description of this discussion will be documented in the preoperative evaluation form.

2. Risk Assessment on the Day of Procedure

A Staff Anesthesiologist will also perform a risk assessment on the day of the procedure immediately before induction of anesthesia. It is the responsibility of this physician to re-evaluate and confirm the previously gathered information immediately prior to rendering anesthesia service and establish the patient’s readiness for the procedure. As part of the anesthesia care team, nurse anesthetists and residents are responsible for assessing and recommending an anesthetic plan for cases in which they are involved, but it is the responsibility of the Staff Anesthesiologist to determine the final anesthetic plan. This assessment will be documented electronically in a progress note in the patient’s medical record.

3. Intra-operative Anesthesia Record

a. The Anesthesia care team will keep a record of the patient’s vital signs, ASA status, anesthetic technique, special monitoring devices, medications used, patient positioning, intra-operative events and time keeping while providing anesthesia service. This will be in concordance with the Standards for Basic Anesthesia Monitoring established by the American Society of Anesthesiologists (ASA).

b. The Staff Anesthesiologist of record will determine the final anesthetic plan including the need for invasive monitoring for each individual.

c. A computer-generated electronic Anesthesia Record form will be documented in CPRS.

4. Operative and Post-operative Surgical Records - General

a. A pre-operative diagnosis is recorded before surgery by the licensed independent practitioner responsible for the patient.

b. Operative Reports will be dictated or written immediately after surgery and will include:

1) Name of the primary surgeon and assistants
2) Operative findings
3) Technical procedures used
4) Specimens removed
5) Post-operative diagnosis

c. When the detailed Operative Report is not placed into the medical record immediately following surgery, a Brief Operative Report is entered immediately as a Progress Note into CPRS.

d. Post-operative documentation records will include:

1) Patient's vital signs and level of consciousness
2) Medications (including intravenous fluids)
3) Blood and blood components administered
4) Any unusual events or postoperative complications
5) Management of such events

e. Post-operative documentation must record patient discharge from the Post-Anesthesia Care Unit by the responsible licensed independent practitioner and document compliance with discharge criteria.

f. Post-operative documentation records the name of the licensed independent practitioner responsible for discharge.

5. Operative/Procedure Reports on Procedures Performed Outside the Operating Room (OR).

a. Electronic documentation of all diagnostic and therapeutic procedures not performed in a main OR or a specialized operating/treatment room will be entered in the patient's CPRS Progress Notes. This documentation signed and authenticated by the responsible Medical Staff member, will consist of the following:

1) The name of the procedure and the date it was performed
2) The name(s) and title(s) of those performing the procedure
3) The indications for the procedure
4) Relevant details concerning the performance of the procedure, including a description of the specimens removed
5) A list of the major findings and conclusions
6) A discussion of complications, including plans for following up on the complications
7) The condition of the patient at the conclusion of the procedure

6. Post-Anesthesia Care Unit (PACU) Admission and Progress Notes

a) Patient will be admitted to the PACU in order to monitor recovery from anesthesia. Guidelines outlined in PACU policies and procedures manual must be followed.

b) The anesthesia care team will give a report to the receiving care giver that includes, but is not limited to, past medical history, allergies, intra-operative information, current status and post-operative instruction. A note describing the occurrence and content of this dialogue must be documented in a CPRS Progress Note or in the anesthesia record.

c) Notes documenting the patient's course in PACU will be entered into CPRS.

d) Patients receiving Monitored Anesthesia Care (MAC) or intravenous sedation analgesia ("Moderate Sedation") may bypass PACU and go directly to second stage recovery or to the unit if the Staff Anesthesiologist considers it appropriate. A note will document this decision in the patient's CPRS record.

7. PACU Discharge Note

After a patient recovers from anesthesia, a Staff Anesthesiologist will assess the patient's recovery status prior to discharge from PACU. Alternatively, the patient may be discharged from PACU, once he/she satisfies the discharge criteria outlined in the "Post Anesthesia Care Unit Policy and Procedure Manual PACU Discharge Criteria", if the Staff Anesthesiologist considers it appropriate. A report on the patient's hemodynamic status, level of consciousness, and recovery status from a regional anesthetic will be documented electronically or on a pre-anesthesia evaluation chart using VA Form 10-585 (549) "DVAMC Anesthesia Record" (hardcopy) prior to discharge from PACU. A review of the PACU nurse's notes including vital signs, medications given, and fluid management will be used to assess the patient prior to discharge.

8. Post-Anesthetic Progress Note

   a) Twenty-four (24) to 72 hours after the procedure, inpatients will be evaluated by a member of the Anesthesiology and Pain Management Service to determine the presence or absence of anesthesia-related problems or complications. Patient status will be documented through an electronic note or a written note in the patient's chart using VA Form 10-585 (549) "DVAMC Anesthesia Record" (hardcopy) if electronic means are unavailable.

   b) A patient discharged home after a same-day procedure will be called by telephone at home by Day Surgery Unit personnel to inquire about patient status and complications as per their unit guidelines. Evidence of anesthesia-related complications obtained via the above-mentioned communication will be communicated immediately by a member of the Day Surgery Unit to the Anesthesiology and Pain Management Service.

   c. All serious complications will be promptly reported to Patient Safety for further investigation.

9. Intravenous Sedation and Analgesia:
   Outside the main Operating Room, patients receiving moderate sedation analgesia (Moderate Sedation) by non-anesthesia providers, will be monitored and followed per the guidelines established in VANTHCS Memorandum No. 112A-02 "Administration of Moderate Sedation/Analgesia (Conscious Sedation)". In addition, non-anesthesia providers must hold privileges for Moderate Sedation.

10. VANTHCS Memorandum No. 112-06, "Organ Donation and Donation of Body For Science" outlines policies and procedures governing the removal of cadaveric organs or tissue for donation.

K. Extended Care Medical Records

1. Patients transferred from acute inpatient care to Extended Care require a completed Discharge Summary prior to their admission to Extended Care.

2. Admission Note

   a) An admission note will be recorded in CPRS by the attending physician within 24 hours of admission. This note will contain an assessment of the factors responsible for admission to Extended Care, including the patient's medical, functional, and mental status.

   b) A History and Physical Examination (H & P) completed and entered into the medical record within 24 hours of admission, will meet the requirements for an admission note.

c) The existence and scope of an Advance Directive on the patient will be documented in CPRS upon admission.

3. H&P

a) A H&P will be completed by the attending physician within 48 hours of admission. This H & P will contain an accounting of the patient's current medical illnesses, medications, allergies, immunization status, social history, systems review, physical findings, and mental status. An initial impression and plan of care will be included. Also, prognosis and potential for rehabilitation will be stated if clinically appropriate. The existence and scope of an Advance Directive on the patient will be documented in CPRS upon admission.

b) An Interval H & P may be utilized if a patient is readmitted to Extended Care within 30 days of discharge.

c) Patients residing in Extended Care for more than one year will receive an annual physical examination, including assessment of current mental and physical status.

d) H&P's written by PAs and APRNs will not require co-signature by the attending physician unless otherwise specified in the individual's scope of practice.

4. Plan of Care

a) An interdisciplinary Plan of Care is developed for each patient admitted for longer than 14 days.

b) Discharge planning will be included in the interdisciplinary Plan of Care.

5. Progress Notes

a) Progress notes are entered into CPRS for Extended Care patients to document changes in the patient's condition as they occur and the patient's response to prescribed interventions. These will be entered no less frequently than every 30 days or within the minimum timeframe required by accrediting agencies such as TJC and Commission on the Accreditation of Rehabilitation Facilities (CARF) or by the patient's changing condition.

b) Progress notes written by subspecialty services for Extended Care inpatients will be entered into CPRS.

6. Doctor's Orders

a) Orders will be entered electronically into CPRS and include the

requirements of acute inpatient care, including date, time and signature of the provider writing the order.

b) Orders written by PAs and APNs will not require co-signature by the attending physician, unless otherwise specified in the individual's scope of practice.

7. Discharge Summary

A Discharge Summary is required on all patients discharged from Extended Care. It will be completed within seven (7) working days from date of discharge.

VII. INFECTION PREVENTION AND CONTROL

A. Infection Prevention and Control Manual – VANTHCS Memorandum 11IPC-01 Infection Prevention and Control (IPC) Program establishes infection control policies (collectively referred to as the infection control manual) to prevent the spread of infection to patients, personnel, and visitors. Infection Prevention and Control standards specific to each service are written in each service's respective standard operating procedures (SOP). A manual is located in every service and every patient care area and on the VANTHCS Intranet site. Refer to Infection Prevention and Control Manual for details.

B. Authority for Infection Prevention and Control - The Chairperson, Infection Control Committee, or delegated alternate, has the authority to determine what measures are necessary to prevent or control transmission of infections and to institute any appropriate control measures with approval by the Chief of Staff. These measures may include, but are not limited to, restricting unit or hospital admissions, cohorting or isolating patients, removing employees from patient contact, and
obtaining appropriate cultures or other tests from patients, staff, or the health care environment.

VIII. DISASTER PREPAREDNESS AND OPERATIONS

A. Emergency Operations Plan

1. The Emergency Operations Plan is detailed on the VANTHCS Intranet site and provides a comprehensive guide to responding to emergency situations that may occur at or involving VANTHCS. It provides an outline for the care of mass casualties. It is to be implemented in the event of a variety of emergencies including fire, severe weather, explosions, utility outages, threats to cause harm or destruction, and/or other disasters involving this health care system. The plan may also be implemented during a community disaster and may require the treatment of civilian casualties. A hard copy of the plan can be found in every Service Chief's office as well as other areas throughout VANTHCS.

2. National Disaster Medical System (NDMS). The health care system's mission assignment is to serve as a Primary Receiving Center (PRC) and a Federal Coordinating Center (FCC) under the NDMS. The NDMS Program is activated under the Federal Response Plan during presidentially declared disasters.

3. Privileging of providers during an emergency is covered in the VANTHCS Emergency Operations Plan (EOP) as well as Article 5 Section 9 of the Bylaws.

B. VA/DOD Contingency Plan

1. General Provisions

   The health care system VA/DOD Contingency Plan has been prepared to comply with Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) mission tasking under Public Law 97-174. The health care system's mission assignment is to serve as PRC, and a FCC under the NDMS.

2. Purpose

   a) The Department of Veterans Affairs and Department of Defense (VA/DoD) Contingency Plan defines the role of the health care system with policies and procedures relative to VA/DoD joint contingency planning, implementation, and support.

   b) Public Law 97-174 (38 U.S.C. 5011.A), the Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act, mandates that VA support the military health care system during and immediately following a period of war or national emergency declared by the President or Congress. This emergency medical preparedness program requires VA health care systems to develop contingency plans to care for the large number of casualties expected in such situations.

3. Scope - This plan is applicable to all employees of VANTHCS. It is a component of the Emergency Operations Plan, supplementing VANTHCS Emergency Preparedness Plan, which may serve as annexes to the VA/DoD Plan where applicable.

4. Implementation - Upon notification by the Secretary of Veterans Affairs, the Under Secretary for Health of the Veterans Health Administration (VHA) will activate the VA component of Contingency Hospital System (CHS). The Heart of Texas Veterans Health Care Network Director, VISN 17, will notify the VANTHCS Director who will initiate the health care system's emergency notification or "Cascade" system, as necessary. Cascade recalls ensure that

appropriate personnel are available in the health care system to provide services consistent with the General Mission Statement Service Plan Section of Emergency Operations Plan).

5. Priority of Care - DOD patients will receive priority care over all VA beneficiaries except service-connected (SC) veterans, or non-service (NSC) veterans with a life-threatening emergency. NSC inpatients who may be discharged without a significant compromise of their health will be released from the health care system; others may be referred to secondary support centers or community hospitals, as appropriate.

6. Outplacement of NSC Patients - Under Public Law 97-174, service-connected veterans retain the highest priority for care in VHA. In a VA/DoD contingency, active duty military personnel receive a higher priority than NSC veterans. Thus, in order to free up beds to meet our mission goal, NSC veterans may be discharged or transferred to other VA or community health care facilities. The attending physician will make the determination as to whether a NSC veteran can be discharged without a significant compromise to his/her health. If it is medically compromising to discharge, but movement is feasible, the patient may be transferred to an assigned VA secondary support center or to a community hospital. This transfer will be made in accordance with the procedure outlined in VANTHCS Memorandum No. 136-08 "Inter-facility Transfer Policy".

NOTE: VA WILL MAINTAIN RESPONSIBILITY FOR CONTINUITY OF CARE FOR PATIENTS WHO ARE DISCHARGED OR TRANSFERRED

7. Responsibilities - Medical Staff member responsibilities during the implementation of the VA/DoD Contingency Plan are outlined in the individual service component of the Emergency Operations Plan.

IX. IMPAIRED PROFESSIONAL PROGRAM

A. The Health Standards Board (HSB) is established for the purpose of determining whether physicians, dentists, podiatrists, optometrists, chiropractors, nurses, physician assistants, expanded-function dental auxiliaries, and residents and interns who are subject to the provisions of VA Handbook 5005, Part II, Chapter 3 are physically fit for appointment or retention in VA employment. For details, see VANTHCS Memorandum No. 11-08, "Health Standards Board".

B. Those cases of questionable nature that have not been resolved, or have been resolved unfavorably by consultation, will be referred to the HSB for determination of physical or mental fitness. The Board will decide whether the individual examined can perform the required service satisfactorily without hazard to VA beneficiaries, employees, or self. The findings of the HSB will be submitted through the Chief of Staff to VANTHCS Director for final disposition.

C. VANTHCS contends that behavioral problems that affect work performance and/or attendance are legitimate concerns of management. Such problems take the form of alcoholism, drug abuse, emotional stress, and other debilitating experiences. VANTHCS considers such problems as health related and has established a procedure for providing employee assistance in such areas. Further details on this program are discussed in VANTHCS Memorandum No. 11-08, "Health Standards Board".

D. Behavior or behaviors by medical staff members that undermine a culture of safety is considered an impairment to provision of safe, high quality patient care. Therefore, Medical Staff members who are consistently disruptive, hostile, or threatening will be referred for pertinent behavior management training such as anger management, interpersonal skills training, and/or team building. If this behavior continues after appropriate referral, the Service Chief will make a recommendation to the ECMS regarding retention of the individual as a member of the Medical Staff.