

**BYLAWS AND RULES OF THE MEDICAL STAFF  
OF  
VETERANS HEALTH ADMINISTRATION (VHA)**

**ROBERT J DOLE VAMC (RJD VAMC)  
WICHITA, KANSAS**

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## **PREAMBLE**

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

RJD VAMC is a full service medical facility comprising comprehensive inpatient and outpatient care.

## **DEFINITIONS**

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

1. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, Advance Practice Professional and/or patient care services at the facility. Both VA employees and contractors (including fee based staff) providing patient care services at the medical center must receive appointments to the Medical Staff.
2. Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when serving in the capacity of Acting Facility Director.
3. Associate Director Patient Care Services (Nurse Executive): The Nurse Executive is a registered nurse who is responsible for overseeing the nursing practice of all nursing staff within the facility and supervision of nursing service. S/he is the Chairperson of the Nurse Practice Council (NPC) and acts as full assistant to the Director in the efficient management of clinical and patient care services. S/he is responsible for the active maintenance of a credentialing and scope of practice system for relevant Advance Practice Professional and certain associated health staff and in ensuring the ongoing education of the nursing staff.
4. Associated Health Professional: As used in this document, the term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine. These professionals include, but are not limited to: Pharmacists (PharmDs), psychologists, podiatrists, audiologists, physical therapists, occupational therapists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.

5. Automatic Suspension of Privileges: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Reactivation must be endorsed by the Clinical Practice Council.
6. Chief of Staff: The Chief of Staff is the Chairperson of the medical staff and Chairperson of the Clinical Practice Council and acts as full assistant to the Director in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioners, Advanced Practice Professionals and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of medical staff.
7. Community Based Outpatient Clinic (CBOC): A health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients. A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures.
8. Medical Center Director (MCD): The MCD (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS), and the Clinical Practice Council.
9. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the Facility Director. The Director is responsible for the oversight and delivery of health care by all employees and specifically including the medical staff credentialed and privileged by the relevant administrative offices and facility approved processes.
10. Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the RJD VA to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians, dentists, optometrists, psychologists, audiologists, physical therapists, occupational therapists, and podiatrists.
11. Medical Staff: The body of all physicians, dentists, optometrists, podiatrists, clinical pharmacy specialists and psychologists holding unrestricted licenses, who are privileged to attend patients in the health care facility. The medical staff is organized into service lines and function under their respective Chiefs of Clinical Services who serve under the Chief of Staff, and are subject to the medical staff bylaws.

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

12. Advanced Practice Professionals: Advanced Practice Professionals are those health care professionals who are not physicians and dentists and who, will, function within a Scope of Practice but may practice independently on defined clinical privileges as defined in these Bylaws. Advanced Practice Professionals include: physician assistants (PA), and advanced practice nurses (APP, CRNA, and CRNP). Advanced Practice Professionals may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations, under the supervision of a credentialed and privileged Licensed Independent Practitioner when required. Advanced Practice Professionals do not have admitting privileges and may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations. Advanced Practice Professionals and other health care professionals may be granted defined clinical privileges when allowed by law and the facility.
13. Organized Medical Staff: The body of Licensed Independent Practitioners who are collectively responsible for adopting and amending medical staff bylaws (i.e., those with voting privileges as determined by the Facility as defined in these Bylaws) and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges.
14. Outpatient Clinic: An outpatient clinic is a healthcare site whose location is within the facility or independent of the medical facility whose oversight is assigned to the medical facility.
15. Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner-specific data collected from various sources for the purpose of evaluating current competence.
16. Primary Source Verification: Documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care Practitioner. This can be a letter, documented telephone contact, or secure electronic communication with the original source.
17. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, etc. to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision.

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

## ARTICLE I. **NAME**

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, RJD VAMC.

## ARTICLE II. **PURPOSE**

The Medical Staff shall:

1. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
2. Assure that all patients shall receive the same standard of care regardless of location.
3. Establish and assure adherence to ethical standards of professional practice and conduct.

4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.
8. Provide a medical perspective, as appropriate, to issues being considered by the Director and Governing Body.
9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.
10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.
11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
12. Provide education and training to residents and students of affiliated training programs, and assure that educational/supervising standards are adhered to.
13. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational policies and procedures.
14. Coordinate and supervise the scope of practice of all Advanced Practice Professional so that practice goals are achieved to provide quality care to the patients. Each Advanced Practice Professional and appropriate associated health practitioner should have a scope of practice to coordinate and supervise their function with the medical staff.

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

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

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, individuals as defined in item 11 of Definitions above.
2. Categories of the Medical Staff: Categories of membership are defined as active, associate, full-time, part-time, consulting, attending, on-station – fee basis, and on-station – contract. Distinction must be made as to which category has a vote. Medical staff membership requires appointment.



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

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

1. Criteria for Clinical Privileges: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial:
  - a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required by VA employment.
  - b. Education applicable to individual Medical Staff members, for example holding a Doctoral level degree in Medicine, Osteopathy, or Dentistry from an approved college or university.
  - c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training.
  - d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying.
  - e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.
  - f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VI or VII or of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff
  - g. Satisfactory findings relative to previous professional competence and professional conduct.
  - h. English language proficiency.
  - i. Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.
  - j. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver's license or passport)
2. Clinical Privileges and Scope of Practice:
  - a. The following Practitioners will be credentialed and privileged to practice independently:

- i) Physicians
  - ii) Dentists
  - iii) Clinical Pharmacy Specialists
  - iv) Podiatrists
  - v) Optometrists
  - vi) Clinical Psychologists
- b. The following Practitioners will be credentialed and practice as defined by their scope of practice with appropriate supervision:
- i) Advanced Practice Nurses (APP) (CRNA) (CRNP)
  - ii) Physicians Assistants
- c. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:
- i) Audiologists
  - ii) Speech Pathologists
  - iii) Licensed Clinical Social Workers
3. Change in Status: Members of the Medical Staff as well as all Practitioners practicing through privileges or a scope of practice must agree to provide care to patients within the scope of their Delineated Clinical Privileges or Scope of Practice and advise the Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges which are held, and any changes in the status of professional credentials, such as, but not limited to, loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society as soon as able, but no longer than 15 days after notification of the practitioner.

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

1. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being on duty as scheduled, (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official

channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

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

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

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

Providers, in their role as patient and peer advocates, are obligated to take appropriate action when observing Behavior or Behaviors That Undermine a Culture

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

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

### **Section 3.04: Conflict Resolution & Management**

For VA to be effective and efficient in achieving its goals the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program*, addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. RJD VA 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 that experience or witness such behavior are encouraged to advise an appropriate supervisor, Patient Safety Officer, or other individual as described in the following Agency resources. The Facility may wish to review the information found on the *Office of Diversity and Inclusion (EEO) website at <http://www.diversity.hr.va.gov/index.asp>* and these resources: *Alternative Dispute Resolution: Memorandum on Alternative Dispute Resolution for Workplace Disputes, (February 8, 2007), VA Directive 5978, Alternative Dispute Resolution (February 23, 2000), and VA Handbook 5978.1, Alternative Dispute Resolution Program: Central Office (December 11, 2007).*

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

### **Section 4.01 Leaders**

1. Chief of Staff.
  - A. Qualifications: The Chief of Staff must possess the clinical and administrative competencies required to discharge the duties of the position, as well as the requisite knowledge and skill to oversee the research and educational missions of the RJD VAMC.
  - B. Selection:

The Network Director approves recommendations to the position of Chief of Staff. The selecting organization is responsible to complete and submit information on the selectee to the Leadership Management and Succession Sub-Committee (LMSS). The LMSS support staff (Executive Recruitment Team) in the Workforce Management and Consulting Office will submit templates to the Leadership Management and Succession Sub-Committee and Workforce Committee for information only.

- C. Removal: All disciplinary and/or adverse actions involving a Chief of Staff position must be referred to the Office of the Accountability Review (OAR). The OAR Employee Relations division will assign an Employee Relations Specialist to work directly with the proposing and deciding officials.

D. Duties:

Chief of Staff serves as Chairperson of the Clinical Practice Council and exercises oversight over all activities under the purview of that committee.

### **Section 4.02 Leadership**

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

### **Section 4.03 Clinical Services**

1. Characteristics:

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

2. Functions:

- a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety, (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; patient safety and risk management activities; and utilization management.
- b. Assist in identification of important aspects of care for the Service, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities.
- c. Maintain records of meetings that include reports of conclusions, data, recommendations, responsible person, actions taken, and an evaluation of

effectiveness of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on an annual basis.

- d. Develop criteria for recommending clinical privileges for members of the Service and ensure that ongoing professional practice evaluation is continuously performed and results are utilized at the time of re-privileging.
  - e. Define and/or develop clinical privilege statements including levels (or categories) of care that include all requirements of VHA Handbook 1100.19.
  - f. Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within the Service.
  - g. Annually review privilege templates for each Service and make recommendations to Clinical Practice Council.
3. Deputy Chief of Staff, or Associate Chief of Staff, or Clinical Service Chief: All are appointed by the Director based upon the recommendation of the Chief of Staff.
4. Duties and Responsibilities: The Deputy Chief of Staff, or Associate Chief of Staff or Clinical Service Chief is administratively responsible for the operation of the Service and its clinical and research efforts, as appropriate. In addition to duties listed below, the Service Chief is responsible for assuring the Service performs according to applicable VHA performance standards. These are the performance requirements applicable to the Service from the national performance contract, and cascade from the overarching requirements delegated to the Chief of Staff. These requirements are described in individual Performance Plans for each Clinical Service Chief. Clinical Service Chiefs are responsible and accountable for:
- a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as Deputy Chief of Staff, or Associate Chief of Staff or Clinical Service Chief.
  - b. Clinically related activities of the Service.
  - c. Administratively related activities of the department, unless otherwise provided by the organization.
  - d. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges through FPPE/OPPE.
  - e. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service.
  - f. Recommending clinical privileges for each member of the Service.
  - g. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the Service and communicating the recommendations to the relevant organizational authority.

- h. The integration of the Service into the primary functions of the organization.
- i. The coordination and integration of interdepartmental and intradepartmental services.
- j. The development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.
- k. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.
- l. The determination of the qualifications and competence of service personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services.
- m. The continuous assessment and improvement of the quality of care, treatment, and services.
- n. The maintenance of and contribution to quality control programs, as appropriate.
- o. The orientation and continuing education of all persons in the service.
- p. The assurance of space and other resources necessary for the service defined to be provided for the patients served.
- q. Annual review of all clinical privilege forms to ensure that they correctly and adequately reflect the services being provided at the facility. This review is noted by the date of review included on the bottom of each privilege delineation form.

## **ARTICLE V. MEDICAL STAFF COMMITTEES**

### **Section 5.01 General**

- 1. Committees are either standing or special.
- 2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.
- 3. The presence of 50% + 1 of a committee's members will constitute a quorum.
- 4. The members of all standing committees, other than the Clinical Practice Council, are appointed by the Chief of Staff and subject to approval by the Clinical Practice Council, unless otherwise stated in these Bylaws.
- 5. The Chair of each committee is appointed by the Chief of Staff, unless otherwise set forth in these Bylaws.
- 6. Robert's Rules of Order will govern all committee meetings.

## **Section 5.02 the Clinical Practice Council (CPC)**

1. Characteristics: The CPC serves as the Executive Committee of the Medical Staff. The voting members of the CPC are:
  - A. Chief of Staff, Chairperson
  - B. Deputy Chief of Staff
  - C. Associate Chiefs of Staff
  - D. Clinical Service Chiefs (Pharmacy, Radiology, Pathology, Psychology, Psychiatry, Social Work, Dental/NVCC, Surgery, Anesthesia, Emergency Medicine, Inpatient Hospitalist).
  - E. Director, Medical Education
  - F. Chief of Quality Management
  - G. ADPCS, Nurse Executive
  - H. Other facility staff may be called upon to serve as resources or attend committee meetings at the request of the chairperson, with or without vote. For example, a Physician Assistant may be called to be present when an action affecting another Physician Assistant is being considered. Any member of the Medical Staff, with or without vote, is eligible for consideration.
  - I. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
  - J. Selection process for membership: Clinical Service Leaders (M.D.s, D.D.S.s and D.O.s)
  - K. Removal process for membership: Staff leaves position.
2. Functions of the Clinical Practice Council:
  - A. Acts on behalf of the Medical Staff between Medical Staff meetings within the scope of its responsibilities as defined by the Organized Medical Staff.
  - B. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process in support of clinical privileges and/or scope of practice requested; to address the scope and quality of services provided within the facility.
  - C. Acts to ensure effective communication between the Medical Staff and the Director.
  - D. Makes recommendations directly to the Director regarding the:
    - i) Organization, membership (to include termination), structure, and function of the Medical Staff.
    - ii) Process used to review credentials and delineate privileges for the medical staff.



- iii) Delineation of privileges for each practitioner credentialed.
- E. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.
- F. Oversees process in place for instances of “for-cause” concerning a medical staff member’s competency to perform requested privileges.
- G. Oversees process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.
- H. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.
- I. Monitors medical staff ethics and self-governance actions.
- J. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.
- K. Receives and acts on reports and recommendations from medical staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body.
- L. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.
- M. Acts as and carries out the function of the Physician Standards Board, which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician. The Physician Standards Board may have the same membership as the local Physician Professional Standards Board or members may be designated for this purpose by the health care facility Director. Boards may be conducted at other VA healthcare facilities.
- N. Provides oversight and guidance for fee basis/contractual services.
- O. Annually reviews and makes recommendations for approval of the Service-specific privilege lists.

3. Meetings:

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

- B. Emergency Meetings: Emergency meetings of the Clinical Practice Council may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the Clinical Practice Council, the Director as the Governing Body or Acting Chief of Staff, acting for the Chief of Staff, may call an emergency meeting of the Committee.
- C. Meeting Notice: All Clinical Practice Council members shall be provided at least 14 days advance written notice of the time, date, and place of each regular meeting and reasonable notice, oral or written, of each emergency meeting.
- D. Agenda: The Chief of Staff, or in his absence, such other person as provided by these Bylaws, shall chair meetings of the Clinical Practice Council. The Chair shall establish the agenda for all meetings and a written agenda shall be prepared and distributed prior to committee meetings.
- E. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the Clinical Practice Council shall be a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
- F. Minutes: Written minutes shall be made and kept on all meetings of the Clinical Practice Council, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff.
- G. Communication of Action: The Chair at a meeting of the Clinical Practice Council at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.

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

1. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Advanced Practice Professionals and Associated health Practitioners (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners and (g) for such additional purposes as may be set forth in the charges to each committee:
2. Information Flow to CPC: All Medical Staff Committees, including but not limited to those listed below, will submit minutes of all meetings to the CPC in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the CPC.

- a. Medical Professional Standards Board:
  - i. Charge: The Medical Professional Standards Board (MPSB) is an extension of the Clinical Practice Council and functions as Credentials Committee. The MPSB is subject to the review and evaluation by the Clinical Practice Council as a whole.
  - ii. Composition: MPSB is comprised of the following:
    - (1) Chief of Staff/Acting Chief of Staff (Chair)
    - (2) Deputy Chief of Staff, Specialty Care
    - (3) Associate Chief of Staff, Primary Care
    - (4) Associate Chief of Staff, Community & Restorative Care
    - (5) Associate Chief of Staff, Behavioral Health
    - (6) Chief of Inpatient Hospitalist Program
    - (7) Director of Medical Education
    - (8) Chief of Emergency Care
    - (9) Chief of Psychiatry Service
    - (10) Chief of Dental Care
    - (11) Chief of Radiology
    - (12) Chief of Pathology
    - (13) Chief of Anesthesia
    - (14) Chief of Clinical Psychology
    - (15) Clinical Pharmacy Specialist
    - (16) Credentialing Supervisor (non-voting)
    - (17) Credentialing Program Assistant (non-voting)
    - (18) HR Technical Advisor (non-voting)
    - (19) Advance Practice Professional Representative (non-voting)
  - iii. Meetings: At the call of the Chairperson or alternate.
- b. Pharmacy and Therapeutics Committee:
  - i. Charge: Recommend professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to pharmaceuticals; recommend programs designed to meet the needs of the professional staff of the Facility for complete current information on matters related to pharmaceuticals and current pharmaceutical practices.

- ii. Composition: Members of Medical, Nursing, Pharmacy, and Administrative Staff.
  - iii. Meetings: At least ten times per year.
- c. Peer Review Committee:
- i. Charge: The Robert J. Dole VA Peer Review Committee serves to review and evaluate the quality of care and services provided by health care professionals in a non-disciplinary educational manner. Protected peer reviews involve members of the health care staff in activities to measure, assess and improve performance and utilization of resources on an organization-wide basis. Authority for protected peer reviews is found in Title 38 U.S.C. 5705, entitled Confidentiality of Medical Quality Assurance Records and its implementing regulations. VHA Directive 2004-051 "Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents" provides detailed guidance.
  - ii. Composition: Peer Review Committee is comprised of the following:
    - (1) Chief of Staff/Acting Chief of Staff (Chair)
    - (2) Associate Director of Patient Care Service (Nurse Executive)
    - (3) Deputy Chief of Staff Specialty Care Service/Designee
    - (4) Associate Chief of Staff, Behavioral Health Service/Designee
    - (5) Associate Chief of Staff Primary Care Service/Designee
    - (6) Associate Chief of Staff Community Care and Rehabilitation/Designee
    - (7) Chief of Inpatient Hospitalist Service/Designee
    - (8) Chief of Surgery/Designee
    - (9) Chief of Emergency Medicine Service/Designee
    - (10) Clinical Pharmacy Specialist/Designee
    - (11) Chief of Anesthesia/Designee
    - (12) Director, Quality Management
    - (13) Risk Manager
    - (15) RN's (2)
    - (16) Ad-Hoc Members providing for appropriate peer representation (per case)
  - iii. Meetings: The Peer Review Committee will meet a minimum of quarterly and more often as the need is identified.
- d. Surgical Workgroup (SWG)

i. Charge: To discuss and review operative mortalities and morbidities for the Department of Surgery and to assist medical staff in reviewing/identifying quality of care issues regarding patient outcomes and resource needs pertaining to in-patient/out-patient operative and invasive procedures done in the operating suites, ambulatory day surgery, endoscopy suites, Dental, and Emergency Room. Surgical Invasive and Operative Procedures and Surgical Morbidity and Mortality reviews will also be conducted. The committee will review the procedures any adverse outcomes to make appropriate recommendations to the Clinical Practice Council (CPC).

ii. Composition: Surgical Workgroup (SWG) is comprised of the following:

- (1) Chief of Surgery
- (2) Chief of Staff
- (3) Surgical Quality Nurses
- (4) OR Nurse Managers

iii. Meetings: Monthly or more frequently as needed.

e. Medical Invasive and Operative Procedure Committee:

i. Charge: To review/identifying quality of care issues regarding patient outcomes and resource needs pertaining to in-patient/out-patient invasive procedures done in the cardiac catheterization laboratory, interventional radiology, in-patient treatment areas (ICU, ER, 3<sup>rd</sup> floor) etc. The committee will review the procedures, adverse outcome if any and will also review the mortality statistics. It will make appropriate recommendations to the Clinical Practice Council (CPC).

ii. Composition:

- (1) Director Specialty Care, Chairperson
- (2) Chief, Cardiology Department
- (3) Medical Director, Cardiac Cath. Lab or designee
- (4) Chief Nurse, Cardiology
- (5) Supervisor Cardiac. Cath. Lab.
- (6) Chief, Radiology Department
- (7) Supervisor, Radiology Department
- (8) Director, Medical Education
- (9) Chief, Inpatient Hospitalist Service or designee
- (10) Chief Nurse, Intensive Care Unit

iii. Meetings: At least ten times per year.

f. Consult Management Committee:

i. Charge: The Consult Management Committee is a standing system-level committee designated to receive, monitor, analyze and address all aspects of consult management to meet the facility's mission and commitment to timeliness of care, provide support to enhance communication of Veterans' needs, and outcome of treatment.

ii. Composition:

- (1) Chief Health Informatics Officer
- (2) Chief of Non-VA Care/Choice
- (3) Clinical Applications Coordinator
- (4) Quality Management, Joint Commission Standards
- (5) Quality Management, EPRP
- (6) Chief, Health Information Management System
- (7) Compliance and Business Integrity Officer
- (8) Analytics Officer
- (9) Group Practice Manager
- (10) Primary Care Representative
- (11) Specialty Care Representative
- (12) Behavioral Health Representative
- (13) Surgery Representative
- (14) Community Care Representative
- (15) Chairs for workgroups/subcommittees

iii. Meetings: At least ten times per year.

g. Access Management Committee:

i. Charge: To establish an Access Management Committee (ACC) delineating scope, membership, and procedures at the Robert J. Dole VA Medical Center.

ii. Composition:

- (1) Group Practice Manager
- (2) Systems Redesign Coordinator
- (3) Data Analyst
- (4) Compliance Auditor
- (5) Chief of Staff
- (6) Clinical Lead, Specialty Care
- (7) Administrative Lead, Specialty Care
- (8) Associate Chief Nurse, Specialty Care
- (9) Clinical Lead, Primary Care
- (10) Administrative Lead, Primary Care
- (11) Nurse Manager, Primary Care
- (12) Clinical Lead, Community Care
- (13) Administrative Lead, Community Care
- (14) Clinical Lead, Behavioral Health
- (15) Administrative Lead, Behavioral Health
- (16) Clinical Lead, Care in the Community/NVCC
- (17) Telehealth Program Manager
- (18) Medical Administration Manager

iii. Meetings: Monthly or more frequently as needed.

h. Medical Records Informatics Committee:

- i) Charge: The purpose of the Medical Records Informatics Committee is exercising oversight and monitoring of processes, accuracy and appropriateness of medical documentation. The Committee will accomplish the following goals: Review of compliance with existing documentation regulations, policies, and legal requirements; assure that medical record documentation meets the needs of Veterans, health care workers, and regulatory agencies; and development of appropriate templates and tools to promote efficient and standardized documentation; directing the implementation, configuration and ongoing maintenance of CPRS and Informatics programs.
- ii) Composition:
  - (1) Chief Health Informatics Officer (Chair)

- (2) Informatics Nurse
- (3) Chief, Medical Administration Service
- (4) Compliance Officer
- (5) Biomed/IT Representative
- (6) Emergency Department Representative
- (7) BH Representative
- (8) Executive Assistant to the Chief of Staff/Designee
- (9) Telehealth Representative
- (10) Quality Management Representative
- (11) Chief, Health Information Management Service
- (12) Deputy Nurse Executive
- (13) Pharmacist
- (14) Associate Chief Nurse, Inpatient Care
- (15) Physician Representative (*if the Chair is not a physician*)

iii) Meetings: At least ten times per year.

i. Disruptive Behavior Committee:

i.) Charge: Define policy and establish guidelines for the Disruptive Behavior Committee (DBC) to process disruptive, threatening or violent behavior that has occurred in the Medical and/or Regional Office Center and Community Based Outpatient Clinics. The DBC will work with employees, treatment providers, and patient/Veterans to prevent, decrease, and /or eliminate disruptive, threatening and/or violent behavior in the facility to maintain a safe environment for patients, staff, contractors, and visitors utilizing the National Patient Record Flagging (PRF) System.

ii.) Composition:

- (1) Behavioral Health Clinician
- (2) Clinician, Alternate Chair
- (3) Patient Safety\*
- (4) Chief of Police
- (5) Patient Advocate Manager\*
- (6) Clerical/Administrative Support
- (7) Executive Assistant to the Chief of Staff



- (8) AFGE Representative
- (9) Program Director, Safety
- (10) Health Information Management\*
- (11) Human Resources\*
- (12) Nursing Service Representative\*
- (13) VHA Educational/Prevention and Management of Disruptive Behavior Program Representative
- (14) Primary Care Representative-Clinician\*
- (15) Regional Counsel\*
- (16) VBA Representative

\*At the call of the Chair

iii.) Meetings: Monthly or more frequently as needed.

j. Research and Development (R&D):

1. Our R&D oversight is provided by the Kansas City VA. The functions of the R&D Program is set forth in the RJD, Human Research Protection Program (HRPP) Policy in accordance with the Belmont Report, Office of Research Oversight VHA Handbook 1058 and R&D VHA Handbook 1200. All Research and Institutional Review Board (IRB) functions take place through The Kansas City VA.
2. The Wichita VA members of the Kansas City VA R&D Committee are appointed by the Wichita Medical Center Director and must reflect the types of research being conducted at the facility. The Wichita VA will provide one individual to serve as a voting member in the Kansas City VA R&D Committee; and one individual to service as a voting member in the Institutional Review Board (IRB) Committee. Ex-officio (non-voting) members include the Research Coordinator, Information Security Officer, and Privacy Officer. RJD VA alternate members are formally appointed as alternate members by the Wichita Medical Center Director.

k. Dementia Steering Committee:

i) Charge: The Dementia Steering Committee will provide local leadership to improve identification and care of veterans with dementia throughout the RJD VA continuum of care. To ensure effective communication with all stakeholders, the RJD VA Dementia Committee will coordinate with the VISN 15 Dementia Steering Committee. The Committee also serves as a consultant and expert

resource on Major Neurocognitive disorders and management of challenging behaviors.

ii.) Composition:

- (1) ACOS, Community Care & Rehabilitation
- (2) ACOS, Behavioral Health
- (3) AO, Community Care & Rehabilitation
- (4) Neurologist
- (5) Director, Community Living Center
- (6) Neuropsychologist
- (7) Psychiatrist
- (8) Inpatient Hospitalist
- (9) Nurse Manager, CLC
- (10) Program Manager, HBPC
- (11) Supervisor, Telehealth
- (12) Physician, Geri-PACT
- (13) Chief, Pharmacy Services
- (14) Representative, Caregiver Support Program
- (15) Chief, Social Work Services

iii) Meetings: At least nine times per year.

I. Critical Care Committee:

i) Charge: To designate membership of the Critical Care Committee and state its responsibilities for establishing policy and procedure for the organization and management of the Intensive Care Unit (ICU), the Step Down Unit (SDU) and the overall coordination of Critical Care. To monitor and evaluate the quality and appropriateness of patient care.

ii) Composition:

- (1) Chair, Medical Director Intensive Care Unit/Step Down Unit
- (2) Alternate Chair, Director, Specialty Care
- (3) Program Support Assistant, Specialty Care
- (4) Administrative Officer, Specialty Care

- (5) Nurse Manager ICU
- (6) Nurse Manager Med/Surg
- (7) Director Emergency Department
- (8) Nurse Manager Emergency Department
- (9) Supervisor, Respiratory Therapy
- (10) Pharmacist
- (11) Infection Control
- (12) Dietitian
- (13) Logistics
- (14) Quality Management
- (15) Sterile Processing
- (16) Education

iii) Meetings: Monthly

m. Transfusion Committee:

i) Charge: To oversee blood use processes in order to provide safe, appropriate administration of blood and blood products for Veteran patients. The blood use process consists of ordering, distribution, handling and dispensing, administering, and monitoring effects.

ii) Composition:

- (1) Chair, Lab Medical Director
- (2) Co-Chair, Blood Bank Supervisor
- (3) Co-Chair, Laboratory Manager
- (4) Medicine
- (5) Patient Safety
- (6) Surgery
- (7) Anesthesia
- (8) Nursing
- (9) Quality Management
- (10) Education
- (11) Hospital Administration
- (12) Emergency Department

(13) Oncology/Hematology

iii) Meetings: Quarterly and at the call of the chairperson, as needed.

**Section 5.04 Committee Records and Minutes**

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

**Section 5.05 Establishment of Committees**

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

**ARTICLE VI. MEDICAL STAFF MEETINGS**

1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least quarterly. A record of attendance shall be kept.
2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the CPC. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Director in writing and stating the reason(s) for the request.
3. Quorum: For purposes of Medical Staff business, 50%+ 1 of the total membership of the medical staff membership entitled to vote constitutes a quorum.

Meeting Attendance: Members of the Organized Medical Staff are encouraged to attend at least 50% of regular Medical Staff meetings.

**ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING**

## **Section 7.01 General Provisions**

1. Independent Entity: RJD VAMC is an independent entity, granting privileges to the medical staff through the Clinical Practice Council (CPC) and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Advanced Practice Professional, and Associated Health Practitioner reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff and Advanced Practice Professional and Associated Health Practitioners must practice under their privileges or scope of practice.
2. Credentials Review: All Licensed Independent Practitioners (LIPs), and all Advanced Practice Professionals who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. All Advanced Practice Professionals will be subjected to full credentials review at the time of initial appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a period not to exceed 2 years.
3. Deployment/Activation Status:
  - a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be placed in a "Deployment/Activation Status" and the credentialing file will remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Practitioner will update the credentialing file to current status.
  - b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the CPC for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.
  - c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.
  - d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care, if needed based on the status of his/her privileges.

4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:
  - a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.
  - b. Federal law authorizing VA to contract for health care services.
5. Initial Focused Professional Practice Evaluation:
  - a. The Initial Focused Professional Practice Evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege-specific competence of a Practitioner who does not have documented evidence of competency performing the requested privilege at the organization. This occurs with a new Practitioner or an existing Practitioner who requests a new privilege. The performance monitoring process is defined by each Service and must include;
    - a. Criteria for conducting performance monitoring
    - b. Method for establishing a monitoring plan specific to the requested privilege
    - c. Method for determining the duration of the performance monitoring
    - d. Circumstances under which monitoring by an external source is required
  - b. An initial Medical Staff appointment does not equate to HR employment. FPPE does not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below;
    - a. Initial and certain other appointments made under 38 U.S.C. 7401(l), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations.
    - b. If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply the same processes to the evaluation of individuals employed under provision of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.
    - c. Clinical Service Chiefs will present the FPPEs before the Professional Standards Board and the discussion will be documented in the MPSB minutes. These minutes will be presented for approval to the CPC followed by the Medical Center Director. Once the FPPE is approved, the provider will be converted to Ongoing Professional Practice Evaluation.
6. Ongoing Professional Practice Evaluation:
  - a. The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification

may require intervention by the medical staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for medical staff leadership. Each service chief should consider what hospital, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.

- b. Charge the Chief Medical Officer with assessing compliance with the requirement that each practitioner be reviewed by a second practitioner in the same discipline, especially solo practitioners. To do so, review might need to be made by a practitioner in a second facility. Compliance will be a mandatory review element during annual credentialing review. The criteria for success will be 100 percent of FPPE/OPPE records for solo practitioners are reviewed by a practitioner in the same specialty. Where input from a same specialty practitioner was not documented, the CMO will require an action plan from the facility to achieve compliance. Each VISN CMO will attest that 100 percent of the solo practitioner FPPE/OPPE folders were reviewed from 12 months subsequent to publication of this memorandum.
  - i.) OPPE must be conducted at a minimum of bi-annually (every 6 months). More frequent OPPE is encouraged.
  - ii.) With very few exceptions, VHA data standing alone is not protected by 38 U.S.C. 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. This includes OPPE, FPPE, and Peer Review documents. Data that is not previously identified as protected by 38 U.S.C. 5705 and is collected as provider-specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program, and compared to pre-defined facility triggers or de-identified quality management data.
  - iii.) In those instances where a practitioner does not meet established performance criteria, the service leader has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service leader recommending the renewal of privileges, but the service leader must clearly document the basis for the recommendation of renewal of privileges.
  - iv.) The Medical Professional Standards Board must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.

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

## **Section 7.02 Application Procedures**

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines. The applicant is bound to be forthcoming, honest and truthful. To be complete, applications for appointment must be submitted by the applicant on forms approved by the VHA, entered into the internet-based VHA VetPro credentialing database, and include authorization for release of information pertinent to the applicant and information listed below. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the Practitioner says the information provided is factually incorrect.
  - a. Items specified in Article III, Section 2, Qualifications for Medical Staff Membership, including:
    - i) Active, Current, Full, and Unrestricted License.
    - ii) Education.
    - iii) Relevant training and/or experience.
    - iv) Current professional competence and conduct.
    - v) Physical and Mental health status.
    - vi) English language proficiency.
    - vii) Professional liability insurance (contractors only).
    - viii) BLS approved program using criteria by the American Heart Association. Clinically active staff nominally includes all physicians, advanced practice professionals and nurses, but facilities are encouraged to consider more broad training opportunities including non-clinical staff.
    - ix) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and will complete Moderate Sedation training in TMS.
  - b. U.S. Citizenship: First consideration must be given to applicants who are citizens of the United States. When it is not possible to recruit qualified U.S. citizens, Practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment with proof of current visa status and Immigration and Naturalization Service documentation regarding employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.



- c. References: The names and addresses of a minimum of three individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. The Facility Director may require additional information.
  - d. Previous Employment: A list of all health care institutions or other organizations where the Practitioner is/has been appointed, utilized or employed (held a professional appointment), including:
    - i) Name of health care institution or practice.
    - ii) Term of appointment or employment and reason for departure.
    - iii) Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary surrender.
  - e. Drug Enforcement Administration (DEA)/Controlled Drug Substances (CDS) Registration: A description of:
    - i) Status, either current or inactive.
    - ii) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, the Practitioner's DEA/CDS registration.
  - f. Sanctions or Limitations: Any sanction or penalty by any licensing authority, including current pending challenges, whether a license or registration ever held to practice a health occupation by the Practitioner has been suspended, revoked, voluntarily surrendered, or not renewed.
  - g. Liability Claims History: Status (Open, Pending, Closed, Dismissed, etc.) of any claims made against the Practitioner in the practice of any health occupation including final judgments or settlements, if available.
  - h. Loss of Privileges: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.
  - i. Release of Information: Authorization for release of information, including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.
  - j. Pending Challenges: Pending challenges against the Practitioner by any hospital, licensing agency, professional group, or society.
2. Primary Source Verification: In accordance with VHA Handbook 1100.19 Credentialing and Privileging and VA Handbook 5005, Part II, Chapter 3 the facility will obtain primary source verification of:
- a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article VIII, Section 8.02.
  - b. Verification of current or most recent clinical privileges held, if available.

- c. Verification of status of all licenses current and previously held by the applicant.
  - d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.
  - e. Evidence and verification of board certification or eligibility, if applicable.
  - f. Verification of education credentials used to qualify for appointment including all postgraduate training.
  - g. Evidence of registration with the National Practitioner Data Bank (NPDB) Continuous Query Update, for all members of the Medical Staff and those Practitioners with clinical privileges.
  - h. For all physicians screening will be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner.
  - i. Confirmation of health status on file as documented by a member of the Organized Medical Staff.
  - j. Evidence and verification of the status of any alleged or confirmed malpractice.
  - k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made.
3. The applicant's attestation to the accuracy and completeness of the information submitted.
  4. Burden of Proof: The applicant has the burden of obtaining and producing all needed information for a proper evaluation of the applicant's professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of the request to the applicant may serve as a basis for denial of employment consideration.
  5. VetPro Required: All healthcare providers must submit credentialing information into VetPro as required by VHA policy.

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

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

2. CMO Review: A review of the applicant's file by the CMO must be initiated to determine to continue the appointment and privileging process prior to presentation to the Clinical Practice Council in the following situations:

- a. If the response from the NPDB continuous query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant,

- (1) Three or more medical malpractice payments
- (2) A single medical malpractice payment of \$550,000 or more
- (3) Two medical malpractice payments totaling \$1,000,000 or more

The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Chief's Approval screen in VetPro as an additional entry.

- b. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions

- c. In these instances, the credentialing process can be started only after CMO approval

3. CPC Recommendation: Clinical Practice Council recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
4. Director Action: Recommended appointments to the Medical Staff should be acted upon by the Director within 30 calendar days of receipt of a fully complete application, including all required verifications, references and recommendations from the appropriate Service Chief and Clinical Practice Council.
5. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or return of the application because of inadequate information.

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

1. Evaluation of Competence: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the Practitioner applying for clinical privileges has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.
2. Good Faith Effort to Verify Credentials: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased,

etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The entry will describe the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. It will also indicate when a secondary source (e.g. copy of diploma, confirmation from someone in practice or training at the same time) is being used in lieu of primary-source verification. The applicant should assist in providing required information for this documentation.

3. Maintenance of Files: A complete and current Credentialing and Privileging (C&P) file including the electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C&P file is the responsibility of the Chief of Staff. Any time a file is found to lack required documentation, without an entry as noted above in paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain such documentation.
4. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a 'for-cause' event requiring a focused review.
  - a. A FPPE, implemented at time of initial appointment, will be based on the Practitioner's previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, chart reviews, etc. and should be discussed with the Practitioner by the Service Chief.
  - b. A FPPE at the time of request for additional privileges will be for a period of time, a number of procedures, and/or chart review to be set by the Service Chief.
  - c. A FPPE initiated by a 'for-cause' event will be set by the Service Chief. FPPE for cause, where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges i.e., summary suspension
  - d. The FPPE monitoring process will clearly define and include the following:
    - i) Criteria for conducting the FPPE.
    - ii) Method for monitoring for specifics of requested privilege.
    - iii) Statement of the 'triggers' for which a 'for-cause' FPPE is required.
    - iv) Measures necessary to resolve performance issues which will be consistently implemented.
  - e. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the Service's policies and procedures.
  - f. If at any time the Service Chief or designee cannot determine the competence of the Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:
    - i) Extension of FPPE review period

- ii) Modification of FPPE criteria
- iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner)
- iv) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported )

### **Section 7.05 Local/VISN-Level Compensation Panels**

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

## **ARTICLE VIII CLINICAL PRIVILEGES**

### **Section 8.01 General Provisions**

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

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

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

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.
2. Requests in Writing: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the core or specific privileges being requested in a format approved by the Medical Staff.
3. Credentialing Application: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
  - a. Complete appointment information as outlined in Section 2 of Article VI.
  - b. Application for clinical privileges as outlined in this Article.

- c. Evidence of professional training and experience in support of privileges requested.
  - d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Clinical Practice Council.
  - e. A statement of the current status of all licenses and certifications held.
  - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
  - g. Applicants are required to provide complete lists of all facilities, current and past, where privileges are or have been held.
  - h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
  - i. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association.
4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.
  5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and complete Moderate Sedation training in Talent Management System (TMS).

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

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:
  - a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic credentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.
  - b. Supporting documentation of professional training and/or experience not previously submitted.

- c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Clinical Practice Council.
  - d. Documentation of continuing medical education related to area and scope of clinical privileges, (consistent with minimum state licensure requirements) not previously submitted.
  - e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.
  - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
  - g. Names and addresses of two peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
  - h. Names of other hospitals or facility at which privileges are held and requests for copies of current privileges held.
2. Verification: Before granting subsequent clinical privileges, the Credentialing and Privileging Office will ensure that the following information is on file and verified with primary sources, as applicable:
- a. Current and previously held licenses in all states.
  - b. Current and previously held DEA/State CDS registration.
  - c. National Practitioner Data Bank (NPDB) Continuous Query Registration.
  - d. Federation of State Medical Boards (FSMB) query Physical and mental health status information from applicant.
  - e. Physical and mental health status confirmation.
  - f. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and FPPE.
  - g. Continuous education to meet any local requirements for privileges requested.
  - h. Board certifications, if applicable.
  - i. Quality of care information.



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

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

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

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.
2. The Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.
  - a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:
    1. Medical/Clinical knowledge.
    2. Interpersonal and Communication skills.
    3. Professionalism.
    4. Patient Care.
    5. Practice-Based Learning & Improvement.
    6. System-Based Practice.
  - b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring

and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE.

3. Clinical Practice Council (CPC), or the committee responsible for the Medical Executive Function, recommends granting clinical privileges to the Facility Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. A subcommittee of CPC can make the initial review and recommendation but this information must be reviewed and approved by the CPC.
4. Clinical privileges are acted upon by the Director within 30 calendar days of receipt of the CPC recommendation to appoint. The Director's action must be verified with an original signature.
5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A Copy of approved privileges is given to the Practitioner and is readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.

### **Section 8.06 Exceptions**

1. Temporary Privileges for Urgent Patient Care Needs: Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of an initial appointment for a limited period of time (not to exceed 60 calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff.
  - a. Temporary privileges are based on verification of the following:
    - (1) One, active, current, unrestricted license with no previous or pending actions.
    - (2) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.
    - (3) Current comparable clinical privileges at another institution.
    - (4) Response from NPDB Continuous Query registration with no match.
    - (5) Response from FSMB with no reports.
    - (6) No current or previously successful challenges to licensure.
    - (7) No history of involuntary termination of medical staff membership at another organization.
    - (8) No voluntary limitation, reduction, denial, or loss of clinical privileges.
    - (9) No final judgment adverse to the applicant in a professional liability action.
  - b. A completed application must be submitted within three calendar days of temporary privileges being granted and credentialing completed.
2. Expedited Process:
  - a. The Practitioner must submit a completed application through VetPro.
  - b. The Facility:

- (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 Continuous Query 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. The MPSB, consisting of at least two voting members of the medical staff, recommends appointment to the medical staff.
  - d. The recommendation must be acted upon by the Facility Director.
  - e. Full credentialing must be completed within 60 calendar days of the date of the Director's/Governing Body's signature and presented to the MPSB.

### 3. Disaster Privileges: As described in the Facility's Emergency Operations Plan

- a. Disaster privileges may be granted only when the Emergency Operations Plan has been activated; and the facility is unable to handle the immediate patient care needs.

The medical center Director or designee may grant Disaster privileges when the EOP has been activated.

The process for granting disaster privileges must include

- i) Identification of the individual(s) responsible for granting disaster privileges.
- ii) A description of the responsibilities of the individual(s) responsible for granting disaster privileges.
- iii) A description of how volunteer licensed independent practitioners will be distinguished from those currently appointed at the facility.
- iv) A description for oversight of the performance of volunteer licensed independent practitioners who are granted disaster privileges.
- v) A description of the mechanism to manage the activities of the health care professionals who are granted disaster privileges, as well as a mechanism to readily identify these individuals.
- vi) A description of the verification process at the time disaster privileges are granted as well as obtaining his/her valid government-issued photo identification (i.e., driver's license or passport) and must also include:
  - (a) A current hospital photo identification card and evidence of current license to practice; or
  - (b) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or
  - (c) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a Federal, state, or municipal entity.
- vii) The MCD will make a determination within 72 hours of the practitioner's arrival if granted disaster privileges should continue based on its oversight of the practitioner
- viii) Primary source verification of licensure must occur as soon as the disaster is under control or within 72 hours from the time the practitioner presents to the facility, whichever comes first. If primary source verification of a practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the facility documents the reason(s) it could not be performed within 72 hours of the practitioner's arrival, evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment, and services, and evidence of the hospital's attempt to perform primary source verification as soon as possible
- ix) The facility process needs to specify the period of time under which these health care professionals granted disaster privileges may practice on these disaster privileges. This period may not exceed 10 calendar days or the

length of the declared disaster, whichever is shorter. At the end of this period the practitioner needs to be converted to Temporary Privileges defined by this policy or be relieved.

- x) A defined process to ensure the verification process of the credentials and privileges of health care professionals who receive disaster privileges that begins as soon as the immediate situation is under control. This process must be identical to the process for granting Temporary Privileges and ultimately result in complete credentialing of these practitioners.

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

- b. When the Practitioner returns to the Facility, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be verified again. Inactivation of privileges may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.
- c. At the time of inactivation of privileges, including separation from the medical staff, the Facility Director ensures that within 7 calendar days of the date of separation, information is received suggesting that Practitioner met generally accepted standards of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.

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

- a. Facility staff request that a Practitioner returning from active duty communicate with the Facility staff as soon as possible upon returning to the area.
- b. After the electronic credentials file has been reopened for credentialing, the Practitioner must update the licensure information, health status, and professional activities while on active duty.
- c. The credentials file must be brought to a verified status. If the Practitioner performed clinical work while on active duty, an attempt is made to confirm the type of duties, the Practitioner's physical and mental ability to perform these duties, and the quality of the work. This information must be documented.
- d. The verified credentials, the Practitioner's request for returning the privileges to an Active Status, and the Service Chief's recommendation are presented to the Clinical Practice Council for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the

Clinical Practice Council is documented and forwarded to the Director for recommendation and approval of restoring the Practitioner's privileges to Current and Active Status from Deployment and/or Activation Status.

- e. In those instances when the Practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.
- f. In those instances where the privileges lapsed during the call to active duty, the Practitioner needs to provide additional references for verification and Facility staff need to perform all verifications required for reappointment.
- g. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief, must consider whether a request for modification of the privileges held prior to the call to active duty should be initiated on a short-term basis.
- h. If the file cannot be brought to a verified status and the Practitioner's privileges restored by the Director, the Practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VetPro:
  - i) Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.
  - ii) Registration with the NPDB Continuous Query with no match.
  - iii) A response from the FSMB with no match.
  - iv) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.
  - v) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

### **Section 8.07 Medical Assessment**

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

## ARTICLE IX INVESTIGATION, SUMMARY SUSPENSION AND ACTION\*

### Section 9.01

**NOTE:** *Article IX addresses the process to be used when the potential for a clinical care concern has been identified. This article defines the steps to be used to gather information of the concern, the employee's clinical job duties and subsequent action to be taken when appropriate.*

1. Concerns Identified: Whenever there are concerns that a Practitioner has demonstrated substandard care, professional (clinical) misconduct, or professional (clinical) incompetence, further information will be gathered to either confirm or refute the legitimacy of the concerns. The individual's immediate supervisor will typically be the individual responsible for conducting a preliminary review of the alleged clinical deficiencies to determine whether a comprehensive focused clinical care review or other administrative review is warranted. The Chief of the Practitioner's clinical service, the Chief of Staff or the Medical Center Director may also initiate a preliminary fact-finding.
2. Documentation: Whenever a preliminary fact finding confirms a concern considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Behavior or Behaviors that Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, further review of the concerns may result in a fact-finding, administrative investigation, or comprehensive focused clinical care review. These findings may result in an administrative action.
  - a. Material that is obtained as part of a protected performance improvement activity (i.e., 38 U.S.C. 5705) may not be used to support an administrative action although performance improvement data, such as that obtained as a result of an Ongoing Professional Practice Evaluation (OPPE) may trigger a more comprehensive review of the Practitioner's work.
  - b. Quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705. Therefore, if such information is necessary in order to conduct a review of the alleged professional deficiencies and any action resulting from the review, it must be developed through mechanisms independent of the performance improvement program, such as a fact-finding, a comprehensive focused clinical care review, an administrative investigation, etc.
3. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care due to the potential of imminent danger to the health and well-being of an individual, including the Practitioner, to summarily suspend all or a portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Medical Center Director. The typical process to be followed in order to summarily suspend a Practitioner's privileges is as follows (for information about the Automatic Suspension of Privileges, see paragraph 6 below):
  - a. The Chief of Staff will make a recommendation to the Medical Center Director that a summary suspension of all or part of the Practitioner's privileges be

invoked because the failure to take such action may result in an imminent danger to the safety and welfare of an individual.

- b. The Medical Center Director will approve the request, if appropriate, and the Practitioner will be issued a notification letter that all or part of the Practitioner's clinical privileges are suspended and include the general reason that the action being taken. This notice will also include information in regards to the requirement to report the individual to the National Practitioner Data Bank (NPDB) if the Practitioner should retire or resign prior to the conclusion of the clinical review and any action resulting from those findings being imposed. **(NOTE:** Management's decision to take a Practitioner out of patient care or place a Practitioner in an authorized leave status due to patient care concerns will result in a summary suspension of clinical privileges being imposed as the underlying reason for such action is due to concerns about the imminent danger to the health or well-being of an individual, and a summary suspension of clinical privileges letter must be issued to the Practitioner immediately.)
- c. Immediately upon the imposition of a summary suspension, the Service Chief or the Chief of Staff will ensure that alternate medical coverage for the Practitioner's patients is provided.
- d. The written notification of summary suspension of clinical privileges affords the Practitioner the opportunity to submit a written response to the concerns identified within the letter within 14 calendar days from receipt of the summary suspension notification letter.
- e. Upon receipt of the Practitioner's written response, the Medical Center Director will determine whether or not the summary suspension of privileges should continue to be imposed pending the outcome of the comprehensive clinical review and any further action imposed as a result of the review. If the decision is made to continue the summary suspension of privileges, the Practitioner's response to the identified issues will be shared with the individual(s) conducting the review of the clinical concerns.

4. Review Process:

- a. When sufficient evidence exists, based on the preliminary fact finding, that a Practitioner may have demonstrated substandard care, professional misconduct or professional incompetence that impacts the Practitioner's ability to deliver safe, high quality patient care, the Chief of Staff will normally appoint one or more impartial clinical care reviewers to complete a comprehensive focused - clinical care review of the concern(s) or issue(s).
- b. The Chief of Staff will determine the appropriate methodology and membership for conducting a review. The individual(s) tasked with performing this review must conduct it in a fair and objective manner, and may be selected from the Practitioner's facility or another facility at the discretion of the Chief of Staff and/or Medical Center Director.



- c. If the Practitioner is not summarily suspended as indicated in paragraph 3 of this Part, the Practitioner will be issued a letter notifying the Practitioner that if he/she resigns or retires while the review is being conducted, the Practitioner may be reported to the National Practitioner Data Bank (NPDB).
- d. The individual(s) who are conducting the comprehensive focused clinical care review have the discretion to meet with the Practitioner to discuss or explain the clinical care concerns. This meeting does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation initiated at the direction of the Chief of Staff is an administrative matter and not an adversarial Hearing. A record of such meeting is made and included with the reviewers' findings, conclusions and recommendations reported to Medical Professional Standards Board that serves as executive committee of the medical staff.
- e. The comprehensive focused-clinical care review is typically completed within 30-calendar days but may be extended if circumstances warrant a longer review period. Documentation in support of an extension should be maintained, and the Practitioner should be notified on regular intervals of the status of the review and the Practitioner being investigated will be apprised of the extension.
- f. The reviewer(s) may review any documentation needed to fully assess the issues (except for those exempt in paragraph 2 above) and/or interview witnesses, including the Practitioner, at their discretion.
- g. The report of the comprehensive focused clinical care review will be made to the Medical Professional Standards Board within *14 calendar days* after the reviewers have completed the investigation. The Medical Professional Standards Board will assess the results and make a recommendation to the Medical Center Director regarding the appropriate action to be taken. The Medical Professional Standards Board has the discretion to meet with the Practitioner within 10 calendar days after receipt of the evidence to ask him/her questions about the findings before reaching a conclusion regarding their recommendations. The Medical Professional Standards Board is not required to meet with the Practitioner, and if the Practitioner fails to meet with Medical Professional Standards Board within *14 calendar days* after the meeting is requested, it must submit its recommendation for action without the Practitioner's input. This proceeding does not constitute a hearing, and there is no entitlement to any procedural rules set forth in Article X of these Bylaws or any other VA regulations. The Medical Professional Standards Board is not required to share the report or any supporting documentation in advance of the proceeding or during the proceeding with the Practitioner. A record of such proceedings will be made and included with the reviewers' findings, conclusions and recommendations that are submitted to the Director.

5. Recommendations Following the Review:

- a. The Medical Professional Standards Board can make the following recommendations to the Director based on the evidence gathered before, during and after the review:
  - i. No action;
  - ii. Initiation of a Focus Peer Performance Evaluation (FPPE);
  - iii. Revocation of privileges; or
  - iv. Reduction in privileges.
- b. Within five (5) business days, the Medical Center Director will review the recommendation of Medical Professional Standards Board, and forward it to the Chief of Staff for appropriate administrative action, if applicable.
- c. No action: If the Medical Center Director concurs with the Medical Professional Standards Board recommendation for no action, the Practitioner will be notified in writing within five calendar days and, if applicable, be notified that privileges are restored.
- d. FPPE:
  - i. If the recommendation is for an FPPE to be initiated, privileges will be reinstated upon the creation and issuance of the FPPE. The FPPE will provide appropriate notification to the Practitioner of the areas of weakness and develop a plan under which the Practitioner can improve in order to successfully complete the FPPE and demonstrate the requisite skill and knowledge in those areas of clinical issues identified as a concern. (**NOTE:** An FPPE will normally be for a minimum of 60-calendar days. In general, extension of the FPPE is discouraged.)
  - ii. Upon completion of the FPPE, results will be reported back to the Medical Professional Standards Board.
- e. Revocation of Privileges:
  - i. If Medical Professional Standards Board recommends that the Practitioner's privileges be revoked, or if a Practitioner fails an FPPE and the Medical Professional Standards Board subsequently recommends the revocation of privileges, the Chief of Staff will assess the evidence and coordinate the separation of the Practitioner with Human Resources Management Service, unless management offers the practitioner a position at the facility that does not require the Practitioner to have clinical privileges.
  - ii. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed removal and proposed revocation of privileges in accordance with VA Handbook 5021, Part II, unless other separation procedures under VA Handbook 5021, Part VI are applicable. If the Practitioner is separated and the Practitioner's privileges are revoked for issues involving

professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board, if applicable.

- iii. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a) (1), the Medical Center Director will issue a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of the right to a fair hearing after the separation is imposed in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.
  - iv. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the procedures in VA Handbook 5021, Part III will be followed unless other separation procedures under VA Handbook 5021, Part VI are applicable. If the Practitioner is separated following these procedures, the Practitioner will be afforded the opportunity for a fair hearing after the separation is imposed in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.
  - v. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for revocation of clinical and privileges and need to remove the Practitioner from the facility. The Practitioner will be separated and subsequently be notified of the right to a fair hearing after separation in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reappointment to the medical center
- f. Reduction of Privileges:
- i. If the Medical Professional Standards Board recommends that the Practitioner's privileges be reduced, or if a Practitioner fails an FPPE and the Medical Professional Standards Board subsequently recommends the reduction of privileges, the Chief of Staff will assess the evidence and coordinate the reduction of the Practitioner's privileges with Human Resources Management Service.
  - ii. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed reduction of privileges and proposed reduction in grade or basic

pay in accordance with VA Handbook 5021, Part II, if the Practitioner's change in privileges will result in a reduction in grade or basic pay. If the Practitioner's grade or basic pay and privileges are reduced for issues involving professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board.

- iii. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a) (1), the Medical Center Director must determine if the Practitioner's services are still needed given the reduction in privileges.
  - a. If it is determined that the Practitioner's services are still needed, management will follow the procedures for modifying a Practitioner's privileges.
  - b. If the Practitioner's services are no longer needed then the Practitioner will be issued a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of right to a fair hearing after separation in accordance with Article X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.
- iv. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the Practitioner may be assigned to duties that do not require a reduction in privileges or the procedures in VA Handbook 5021, Part III will be followed, unless other separation procedures under VA Handbook 5021, Part VI are applicable. (**NOTE:** Probationary employees cannot be issued a major adverse action, and thus a suspension, transfer of function, reduction in grade or basic pay is not an option.) If the Practitioner is separated, he/she will be afforded the opportunity for a fair hearing after separation in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.
- v. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for reduction of clinical and privileges. If the Practitioner's services are no longer needed, the Practitioner will be separated from the contract and subsequently be notified of the right to a fair hearing after separation in accordance with Part X of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation from the contract is for

substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. If it is determined that the Practitioner's services are still needed, management will notify the Practitioner of the right to a fair hearing of the reduction of clinical privileges in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the reduction are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB.

6. Automatic Suspension of Privileges:

- a. An automatic suspension of privileges occurs immediately under the occurrence of an event that may include, but is not limited to, the following:
  - i. The Practitioner is being investigated or was indicted for a misdemeanor or felony. The privileges may only be reinstated after the outcome of the legal issue is finalized and after a determination is made regarding the nexus between the legal issue and the mission of VA.
  - ii. The Practitioner is being investigated for conduct or behavior issues that do not have an impact on patient care but management has determined it could negatively impact the work environment.
  - iii. The Practitioner is being investigated for the fraudulent use of Government equipment or a Government-issued credit card.
  - iv. The Practitioner fails to maintain the mandatory requirements for membership to the medical staff.
- b. Immediately upon the imposition of an automatic suspension, the Service Chief or the Chief of Staff will ensure that alternate medical coverage for the Practitioner's patients is provided.
- c. The Medical Center Director may initiate an appropriate review of the concern(s) or issues(s) resulting in the automatic suspension to include recommendations for appropriate administrative action.
- d. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in 1 calendar year, a thorough assessment of the need for the Practitioner's services must be performed, documented in writing, and appropriate action taken.

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

- a. The appointment of an ad hoc committee investigation committee;

- b. The conduct of an investigation into a matter;
- c. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview, conference, or proceeding before the Credentials Committee, any ad hoc investigating committee, the Chief of Staff, or any other committee or sub-committee with appropriate jurisdiction in connection with any investigation conducted prior to a proposed adverse recommendation or action;
- d. The failure to obtain or maintain any mandatory requirement for Medical Staff membership;
- e. The imposition of proctoring or observation on a Medical Staff member, which does not restrict clinical privileges or the delivery of professional services to patients;
- f. Corrective counseling;
- g. A recommendation that the Practitioner be directed to obtain retraining, additional training, continued education, or placement on an FPPE; or
- h. Any recommendation or action not “adversely affecting” (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.

## **ARTICLE X FAIR HEARING AND APPELLATE REVIEW \***

### **Section 10.01 Reduction of Privileges**

1. Reduction of Privileges: (**NOTE:** All time frames in this section are required by 1100.19.)
  - a. Prior to any action or decision by the Director regarding reduction of privileges, that does not also involve a major adverse action, such as a suspension, reduction in grade, or reduction in basic pay, as defined in VA Handbook 5021, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:
    - i) A description of the reason(s) for the change.
    - ii) A statement of the Practitioner’s right to be represented by counsel or a representative of the individual’s choice, throughout the proceedings.
  - b. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff’s written notice of intent and receipt of all evidence. The Practitioner must submit a response within 10 business days of the Chief of Staff’s written notice. If requested by the Practitioner, the Chief of Staff may grant an

extension for a brief period, normally not to exceed 10 additional business days except in extraordinary circumstances.

- c. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the Practitioner disagrees with the Director's decision, a hearing may be requested. The Practitioner must submit the request for a hearing within five (5) business days after receipt of decision of the Director.
- d. A proposed action taken to reduce a Practitioner's privileges will be made in accordance with VHA Handbook 1100.19. In instances where reduction of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code, the proposed reduction of privileges will be combined with a major adverse action (e.g. suspension, reduction in basic pay, reduction in grade, transfer, etc.) in accordance with Section 7461 7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations. (**NOTE:** A major adverse action may not be proposed against a 38 U.S.C. Section 7403 or Section 7405 (except nurses) employee, or a contractor)

## 2. Convening a Panel:

- a. A panel is not convened if a reduction in clinical privileges is combined with a major adverse action, such as a suspension, reduction in grade, or a reduction in basic pay, due to substandard care, professional misconduct or professional incompetence. A reduction in basic pay may occur when a physician's salary is reduced by a pay panel as a result in a reduction in privileges. In those instances, the proposed reduction and proposed major adverse action are taken together in accordance with the provisions of VA Handbook 5021, Part II.
- b. In the case of a reduction in clinical privileges that does not constitute a major adverse action or is not combined with a major adverse action in accordance with VA Handbook 5021, the facility Director must appoint a review panel of at least three unbiased professionals, within 5 business days after receipt of the Practitioner's request for a hearing. These professionals will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:
  - i. The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 business days and not more than 30 business days from the date of the notification letter.
  - ii. During such hearing, the Practitioner has the right to:

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

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

3. The panel must complete the review and submit the report within 15 business days from the date of the close of the hearing. The panel may request in writing that the Facility Director grant additional time due to extraordinary circumstances or cause.
  - a. The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.
  - b. The facility Director must issue a written decision within 10 business days of the date of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.
  - c. If the Practitioner wishes to appeal the Director's decision, the Practitioner may appeal to the appropriate VISN Director within 5 business days of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.
  - d. The VISN Director must provide a written decision, based on the record, within 20 business days after receipt of the Practitioner's appeal.

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

4. The hearing panel chair shall do the following:

- a) Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross



examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

- b) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.
- c) Maintain decorum throughout the hearing.
- d) Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
- e) Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.
- f) Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.
- g) Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

#### 5. Practitioner's Rights:

- a) The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, (provided that this representative does not have a conflict of interest) cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.
- b) The Practitioner may submit a written appeal to the VISN Director within 5 business days of receipt of the Director's decision, if he/she is in disagreement with the decision rendered.
- c) If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, for greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

### **Section 10.02 Revocation of Privileges**

#### 6. Revocation of Privileges:

- a. Proposed action taken to revoke a Practitioner's privileges will be made in Accordance with VHA Handbook 1100.19 and the following regulations are applicable:

- i) In instances where revocation of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations.
  - ii) For probationary employees appointed under 38 U.S.C. 7401(1) and part-time temporary registered nurses appointed under 38 U.S.C. 7405; the Professional Standard Board (PSB) will convene in accordance with the procedures outlined in VA Handbook 5021, Employee/Management Relations. If separation is recommended and the recommendation from the PSB is based in whole, or in part, for reasons of substandard care, professional incompetence, or professional misconduct, the Director, or designee, may separate the Practitioner as prescribed in VA Handbook 5021. Separation constitutes an automatic revocation of clinical privileges, which is reportable to the NPDB, if the Practitioner is a physician or dentist, but only after being afforded due process. All practitioners, whether reportable to the NPDB or not, are entitled to due process. Refer to Article X, Section 10.01, para 2 for due process procedures.
  - iii) In instances where the Practitioner is appointed through a contract or other "at will" appointment, including but not limited to part-time (excluding part-time temporary registered nurses who are covered under the procedures in para 5(a)(ii), fee basis, without compensation, or intermittent appointment, separation may occur immediately, but separation constitutes an automatic revocation of clinical privileges and is reportable to the NPDB if the Practitioner is a physician or dentist, and the revocation is for substandard care, professional incompetence, or professional misconduct. A report to the NPDB may not be filed until all due process has been exhausted. Refer to Article X, Section 10.01, para 2 for due process procedures.
- b. Revocation procedures will be conducted in a timely fashion. Revocation of clinical privileges may not occur unless the Practitioner is also discharged, separated during probation, or the appointment is terminated. However, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the Practitioner is a physician or dentist and the revocation of privileges and subsequent reassignment constitutes a major adverse action due to a reduction in grade or basic pay, is for reasons of substandard care, professional incompetence, or professional misconduct (e.g., a surgeon's privileges for surgery may be revoked, and the surgeon may be reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility). Any recommendation by the Medical Professional Standards Board for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X, section 10.01, para 2 of these Bylaws.

7. Reporting to the National Practitioner Data Bank<sup>1</sup>:

- a. Tort (“malpractice”) claims are filed against the United States government, not individual Practitioners. There is no direct financial liability for named or involved Practitioners. Government attorneys (Regional Counsel, General Counsel, considers the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.
- b. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioners should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.
- c. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist Regional and General Counsel in defending the case and in decisions concerning denial or settlement.
- d. Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff’s case when a tort claim settlement is submitted for review.
- e. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physicians and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4. The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension if greater than 30 days will be reported.

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

9. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38

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<sup>1</sup> Reference VHA Handbook 1100.17.

U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

## **ARTICLE XI RULES AND REGULATIONS**

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

## **ARTICLE XII: AMENDMENTS**

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from CPC. Changes to the bylaws are amended, adopted and voted on by the Medical Staff as a whole and then approved by the Director. The Bylaws are amended and adopted by endorsement of the majority of the Medical Staff.
2. The Executive Committee may provisionally adopt and the Director may provisionally approve urgent amendments to the Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the medical staff. After adoption, these urgent amendments to the Rules and Regulations will be immediately communicated back to the 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 III, Section 3.04 will be followed.
3. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
4. All changes to the Bylaws require action by both the Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.
5. Changes are effective when approved by the Director.

### **ARTICLE XIII: ADOPTION**

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

If the voting members of the Medical Staff propose to adopt a rule, regulation, or policy or an amendment thereto, they must first communicate the proposal to the Executive Committee. If the Executive Committee proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the Medical Staff. When the Executive Committee adopts a policy or amendment thereto, it must communicate this to the Medical Staff.

### **RECOMMENDED**

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ARACELI REVOTE, MD  
Chief of Staff

### **APPROVED**

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FRANCISCO VAZQUEZ, MBA  
Medical Center Director

## MEDICAL STAFF RULES

### 1. GENERAL

- A. The Rules relate to role and/or responsibility of members of the Medical Staff and individuals with clinical privileges in the care of any and all patients.
- B. Rules of Departments or Services will not conflict with each other, rules and policies of the Medical Staff, or with requirements of the Governing Body.
- C. The Medical Staff as a whole shall hold meetings at least annually.
- D. The Clinical Practice Council serves as the executive committee of the Medical Staff and in between the annual meetings, acts on their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.
- E. Each of the clinical Services shall conduct meetings at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by medical staff and responsible party of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.
- F. Information used in quality improvement as referenced in Article IX, cannot be used when making adverse privileging decisions.

### 2. PATIENT RIGHTS

- A. Patient's Rights and Responsibilities: This Organization supports the rights of each patient and publishes policy and procedures to address rights including each of the following:
  - i) Reasonable response to requests and need for service within capacity, mission, laws and regulations.
  - ii) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
  - iii) Collaboration with the physician in matters regarding personal health care.
  - iv) Care management including assessment, treatment and education.
  - v) Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.
  - vi) Formulation of advance directives and appointment of surrogate to make health care decisions (38 CFR17.32).
  - vii) Access to information necessary to make care decisions that reflect patient's wishes, including potential outcomes, risks and benefits and consequences of refusal of treatment.
  - viii) Access to information about patient rights, handling of patient complaints.

- ix) Participation of patient or patient's representative in consideration of ethical decisions regarding care.
- x) Access to information regarding any human experimentation or research/education projects affecting patient care.
- xi) Personal privacy and confidentiality of information.
- xii) Action by a legally authorized person to exercise a patient's rights if a patient is judged incompetent in accordance with law or is found by a physician to lack medical decision making capacity or unable to communicate his/her wishes.
- xiii) Authority of Chief of Staff or designee to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who lacks medical decision making capacity to provide informed consent (when no next of kin is available).
- xiv) Foregoing or withdrawing life-sustaining treatment including resuscitation.
- xv) Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.

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

- i) Life-sustaining treatment will be provided, consistent with prevailing medical practice, when the patient with medical decision making capacity consents or in emergent situations where informed consent may be implied. Patients with medical decision making capacity have the right to consent or decline any treatment including the provision of life-sustaining treatment. When the patient with medical decision making capacity withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.
- ii) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with other members of the treatment team as appropriate (38 USC sections 7331).
- iii) The attending physician when documenting patient medical decision making capacity concerning life-sustaining treatment, will document the following in the medical record as appropriate: The patient's diagnosis and prognosis; an assessment of the patient's medical decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.
- iv) Patients with medical decision making capacity may be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning life-sustaining treatment will be honored, and will be documented in the medical record.

- v) Advance Directives: The patient's right to direct the course of medical care is not relinquished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any patient with decision making capacity may execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a declarant at any time.
- vi) Substituted Judgments: The rights of patients to direct the course of medical treatment are not relinquished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, 'Substituted Consent' shall be secured from the surrogate decision maker of a patient who lacks decision making capacity prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's 'surrogate' for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:
  - (a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.
  - (b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.
  - (c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the best interest of the patient's care. In cases where the attending physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may



decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body, or Chief of Staff.

### **3. RESPONSIBILITY FOR CARE**

#### **A. Conduct of Care**

- i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff.
  - (a) The attending Staff Physician is responsible for the preparation and completion of a complete medical record for each patient. This record shall include a medical examination, an updated problem list, identification data, chief complaints, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathological findings, progress notes, doctor's discharge instructions sheet, including condition on discharge (discharge note) and final diagnosis, and final summary.
  - (b) A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA regulations and hospital policy. The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.

Medical Assessment of the patient may include:

- a. Medical history, including:
  - 1. Chief complaint
  - 2. Details of present illness
  - 3. Relevant past, social and family history
  - 4. Inventory by body system, including pain assessment
  - 5. Summary of the patient's psychological needs
  - 6. Report of relevant physical examinations
  - 7. Statement on the conclusions or impressions drawn from the admission history and physical examination
  - 8. Statement on the course of action planned for this episode of care and its periodic review
  - 9. Clinical observations, including the results of therapy

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

- (a) Food and nutrition products are administered only on the prescription or order of a Medical Staff member, an authorized house staff member, or other individual who has been granted authority to write such prescriptions or orders, within their scope of practice.
  - (b) Progress note entries should be identified as to the type of entry being made, (e.g., Resident Note, Attending Note, Off Service Note, etc.). The Attending Note must be signed by the Attending physician.
  - (c) Progress notes will be written by the Practitioner at least once daily on all acutely ill patients. Progress notes are written for all patients seen for ambulatory care by the medical staff.
  - (d) Evidence of required supervision of all care by the attending physician shall be documented in the medical record, the frequency of notes dependent upon the severity of the illness of the patient. It is a cardinal principle that responsibility for the care of each patient lies with the staff physician to whom the patient is assigned and who supervises all care rendered by residents.
  - (e) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written or, at minimum, countersigned by the attending physician in the patient's medical record within 24 hours. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient's rights will be upheld.
- 
- ii) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and across Departments and Services and between all staff members who have clinical privileges.
  - iii) There is to be a comparable level of quality of surgical and anesthesia care throughout the Facility.

B. Consultations:

- i) Consultant: A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff and the Professional Standards Boards on the basis of an individual's training, experience, and competence.
- ii) Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation. In the event of an e-Consult there is no requirement of a physical examination.
- iii) Responsibility for Requesting Consultations: The patient's physician, through the Chiefs of Services, shall make certain that members of the staff do not fail in the matter of providing consultation as needed.
- iv) Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.

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

- i) Discharge planning provides for continuity of care to meet identified needs.
- ii) Discharge planning is documented in the medical record.
- iii) Criteria for discharge are determined by the Multidisciplinary Treatment Team.
- iv) Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.

D. Discharge

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

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

#### E. Autopsy

- i) The availability of autopsy services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within the Facility.
- ii) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-170. Whenever possible, the physician responsible for the care of the patient at the time of death will be designated to request permission from the next of kin to perform an autopsy. Already Correct
- iii) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.170, and VHA Handbook 1106.01.
- iv) Autopsy Rates. Autopsies are encouraged as per VHA policy.
- v) Autopsy Criteria. VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in 38 CFR 17.170 VHA Handbook 1106.01. Those cases meeting criteria as Medical Examiner's cases per policy will be referred to the appropriate County Medical Examiner's Office in accordance with state statutes.
- vi) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes.

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

## 2. **PHYSICIANS' ORDERS**

### A. General Requirements

- i) Orders are entered into the electronic medical record (EMR).
- ii) Verbal orders are allowed in emergency or extenuating circumstances.
- iii) Verbal and telephone orders will be accepted when the provider is not in the facility or does not have ready access to CPRS. They will be accepted by Registered Nurses, Pharmacists, Physician Assistants, Advanced Practice Registered Nurses, Certified Registered Nurse Anesthetists, etc. as designated by facility policy and when it clearly is in the best interest of

patient care and efficiency. Appropriate staff receiving the order will first write down the verbal order and read back the order to the provider to ensure accuracy. Verbal and telephone orders will be entered by the accepting staff and signed electronically according to facility policy.

#### B. Medication Orders

- i) All drugs used in the Facility must be on the National Formulary and additions as approved by the VISN Pharmacy and Therapeutics (P&T) Committee or be Investigational Drugs that have been approved by the Research and Development Committee and the Facility P&T committee. Exceptions to the foregoing requirements may be made in use of 'prior approval' or 'non-formulary drugs' which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN level. Exceptions are based on an individual patient case by case basis.
- ii) All drugs used in the Facility will be stored and dispensed by the Pharmacy.
- iii) Duration of Orders:
  - (a) Schedule II controlled drugs will be written for periods not to exceed seven (7) days for in-patients and must be reentered by electronic entry into EMR for each succeeding period of 7 days or less. (Exceptions are when otherwise specified by the provider in the order for up to 15 days such as in long term care unit.)
  - (b) Schedule III – V controlled drugs may be written for a period not to exceed twenty-eight (28) days on medical/surgical/ICU and ninety (90) days in long term care unit.
  - (c) Antibiotics orders must include the duration of the therapy.
  - (d) Orders for all other drugs will be written for a period not to exceed twenty eight (28) days from the date the first medication was ordered before they expire and must be rewritten.
- iv) Ambulatory Care Medication Orders:
  - (a) All prescriptions must be entered electronically.
  - (b) Ninety (90) days is the maximum duration for applicable outpatient prescriptions.
  - (c) The number of refills authorized on a single prescription may not exceed one year.
- v) Transfer of Patients: When a patient is transferred from one level of care to another level of care, or there is a change in physician of record, all orders must be reviewed and revised as appropriate for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.

- C. Standardized Order Sets (protocols): All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by medical staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief.
- D. Investigational Drugs: Investigational drugs will be used only when approved by the appropriate Research and Development Committee and the P&T Committee and administered under approved protocol with patient informed consent, under the direct supervision and legitimate order of the authorized Principal Investigator or designated investigator.
- E. Informed Consent:
  - i) Informed consent will be consistent with legal requirements and ethical standards, as described in Facility Informed Consent Policy.
  - ii) Informed consent should be documented in the medical record before procedures or treatment for which it is required.
- F. Submission of Surgical Specimens: All tissues and objects except teeth or foreign bodies removed at operation shall be sent to the Facility pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.
- G. Special Treatment Procedures:
  - i) DNR (Do Not Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment
    - (a) A description of the role of the physician, family members and when applicable, other staff in decision.
    - (b) Mechanisms for reaching decisions about withholding of resuscitative treatment, including mechanisms to resolve conflicts in decision making.
    - (c) Documentation in the medical record.
    - (d) Requirements are described in Facility Policy Memoranda, Medical Staff Bylaws, and these Rules.
  - ii) Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and may be utilized only within the guidelines of an established protocol in the center policy related to Sedation/Analgesia and according to approved privileges. Only by those Practitioners with approved and current privileges to do so.

### **3. ROLE OF ATTENDING STAFF**

- A. Supervision of Residents and Non-Physicians
  - i) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities.

- ii) Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment.
- iii) Advanced Practice Professionals and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

B. Documentation of Supervision of Residents and non-Physicians

- i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.
- ii) Entries in the medical record made by residents or those non-physicians that require countersigning by supervisory or attending medical staff members are covered by appropriate Facility policy and include:
  - (a) Medical history and physical examination.
  - (b) Discharge Summary.
  - (c) Operative Reports.
  - (d) Medical orders that require co-signature.
    - (1) DNR.
    - (2) Withdrawing or withholding life sustaining procedures.
    - (3) Certification of brain death.
    - (4) Research protocols.
    - (5) Investigational drug usage, ONLY permitted by named principal investigators or co-investigators previously designated in the study.

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

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

and above standard setting-specific documentation requirements (VHA Handbook 1400 page 6).

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

#### **4. MEDICAL RECORDS**

##### **A. Basic Administrative Requirements:**

- i) Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify author, may include written signatures.
- ii) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Advanced Practice Professionals.
- iii) A list of abbreviations not to use can be found in related Facility policy, and is available in CPRS and VISTA. Those abbreviations are not acceptable for use in the medical record.
- iv) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.
- v) Release of information is required per policy and standard operating procedures for the Facility.
- vi) All medical records are confidential and the property of the Facility and shall not be removed from the premises without permission (ROI from the Patient/consultation with the privacy officer as appropriate). Medical records may be removed from the Facility's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.
- vii) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

##### **B. All Medical Records must contain:**

- i) Patient identification (name, address, DOB, next of kin).
- ii) Medical history including history and details of present illness/injury.
- iii) Observations, including results of therapy.



- iv) Diagnostic and therapeutic orders.
- v) Reports of procedures, tests and their results.
- vi) Progress notes.
- vii) Consultation reports.
- viii) Diagnostic impressions.
- ix) Conclusions at termination of evaluation/treatment.
- x) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in Facility Policy Memorandum 'Informed Consent.'

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

- i) A history and physical that includes chief complaint, history of present illnesses, past history, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, and review of systems; complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self-care, mentation, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient assessed personal history. Key examination medical impressions will be documented in the note. The note must be authenticated by provider at the earliest possible time, but always within 24 hours of being written in CPRS.
  - (a) If the H&P was completed prior to the admission or procedure, it must be updated the day of admission. If it is more than 30 days old, a new one must be completed.
  - (b) Inpatient H&P must be completed within 24 hours, and 7 days for the Domiciliary
- ii) Daily progress notes
- iii) Discharge summary/note completed no later than 24 hours of discharge.
- iv) Have a discharge summary (signed) (from inpatient or Domiciliary) available for review in CPRS within 2 business days of discharge from the inpatient setting and 3 business days for CLC residents.

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

- i) A progress note for each visit.
- ii) Relevant history of illness or injury and physical findings including vital signs.

- iii) Patient disposition and instruction for follow-up care.
- iv) Immunization status, as appropriate.
- v) Allergies.
- vi) Referrals and communications to other providers.
- vii) List of significant past and current diagnoses, conditions, procedures, drug allergies,
- viii) Medication reconciliation, problem, and any applicable procedure and operations on the Problem List

E. Surgeries and Other Procedures:

- i) All aspects of a surgical patient's care, including ambulatory surgery, pre-operative, operative and post-operative care, must be documented. Surgical interventions, diagnostic procedures, or other invasive procedures must be documented to the degree of specificity needed to support any associated coding data and to provide continuity of care.
- ii) Preoperative Documentation:
  - (a) In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising or staff Practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed; discussion with the patient and family of risks, benefits, potential complications; and alternatives to planned surgery and signed consent.
  - (b) Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical or Subjective/Objective/Assessment/Plan (SOAP) note addressing pertinent positive/negative information, indications for the procedure, known risks related to the procedure, and a physical exam pertinent to the procedure. A formal consultation to the service for performing the procedure that includes all required content will serve as an H&P if done w/in 30 days, but must be updated the day of the procedure.
  - (c) Except in an emergency, no patient may go to the operating room without a complete history and physical examination recorded in his/her chart plus recorded results of lab work and x-rays as indicated.
  - (d) A surgical operation shall be performed only with documented informed consent of the patient or his/her legal representative except in emergencies at which time the Chief of Staff holds jurisdiction.
- iii) Immediate Post-Operative Documentation: A post-operative progress note must be written, or directly entered into the patient's health record, by the surgeon immediately following surgery and before the patient is transferred to the next level of care.

- (a) The immediate post-operative note must include:
  - (1) Pre-operative diagnosis
  - (2) Post-operative diagnosis
  - (3) Technical procedures used
  - (4) Name of the surgeon/s
  - (5) Findings
  - (6) Specimens removed
  - (7) Blood loss
- (b) The immediate post-operative note may include other data items, such as:
  - (1) Type of anesthesia used
  - (2) Drains
  - (3) Tourniquet Time
  - (4) Plan
- iv) Post-Operative Documentation: An operative report must be completed by the operating surgeon immediately following surgery. Immediately means upon completion of the operation or procedure, before the patient is transferred to the next level of care. The body of the report needs to contain the: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative diagnosis; names of the supervising Practitioner, primary surgeon, and assistants; and the presence and/or involvement of the supervising Practitioner.
- v) Post Anesthesia Care Unit (PACU) Documentation:
  - (a) PACU documentation must include the patient evaluation on admission to, and discharge from, the post-anesthesia care unit, a time-based record of vital signs and level of consciousness (either paper or electronic), all drugs administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post-procedural complications, and post-anesthesia visits.
  - (b) The health record must document the name of the LIP responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.
  - (c) For inpatients, there needs to be at least one documented post-anesthesia visit after leaving the post-anesthesia care unit. The note needs to describe the presence or absence of anesthesia-related complications.

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

## **5. INFECTION CONTROL**

- A. Isolation is described in Infection Control Policy
- B. Standard Precautions are described in Infection Control Policy
- C. Reportable Cases are described in Infection Control Policy

## **6. CONTINUING EDUCATION**

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

## **7. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM**

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

- A. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Chief or Chief of Staff.
- B. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable hospital policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational Health Program or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.
- C. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable hospital

policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational Health Program or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.

- D. VA and Facility policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for physicians, dentists, and other healthcare professionals.
- E. Confidentiality of the Practitioner seeking referral or referred for assistance will be maintained, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.
- F. The hospital will sponsor periodic educational program regarding illness and impairment issues. Licensed independent Practitioners will be issued written information regarding illness issues at the time of initial appointment and re-appointment to the medical staff.

## 8. PEER REVIEW

**NOTE:** Please refer to the following resource when considering changes to this section:  
[http://www1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=1638](http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1638)

- A. All Medical Staff members shall participate in the facility protected peer review program established by the appropriate VHA policy.
- B. All Medical Staff members will complete ongoing required training associated with the associated VHA policy.

## REFERENCES:

National Directive, Handbooks, Memorandums, Notices, etc.

<http://www1.va.gov/vhapublications/ViewPublication.asp?pub>

- i) *Smoking Policy – VHA Directive*
- ii) *Requirements for CPR certification (BLS or ACLS) CPR Policy – VHA Directive*
- iii) *Adverse Events to Patients --VHA Directive*

- iv) *Quality Management System --VHA Directive*
- v) *Patient Safety Improvement—VHA Handbook*
- vi) *Conflict of Interest--VHA Handbook*

Station Level Circulars and Standard Operating Procedures (SOP's):

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- vii) *Requirement for Time and Attendance; Part Time Physician Time and Attendance, Center Circular*
- viii) *Restraint and Seclusion; Use of Restraints, Center Circular Suicide Assessment. Suicide Prevention and Management, Center Circular*

Adopted by the Medical Staff, Robert J  
Dole VAMC, Wichita, Kansas, August  
20, 2016

**RECOMMENDED**

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ARACELI REVOTE, MD  
Chief of Staff

**APPROVED**

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FRANCISCO VAZQUEZ, MBA  
Medical Center Director