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

EASTERN KANSAS HEALTH CARE SYSTEM
LEAVENWORTH, KANSAS
TOPEKA, KANSAS

REVIEWED DATE: 6/22/2016

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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 Eastern Kansas Health Care System (hereinafter sometimes referred to as EKHCS) 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.

EKHCS comprises The Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas; The Colmery-O'Neil VA Medical Center, Topeka, Kansas; all Community Based Outpatient Clinics associated with the VA Eastern Kansas Health Care System.

The Community Based Outpatient Clinics associated with EKHCS are located in the following locations:

Chanute, Kansas
Emporia, Kansas
Fort Scott, Kansas
Garnett, Kansas
Junction City, Kansas
Kansas City, Kansas
Lawrence, Kansas
Platte City, Missouri
St. Joseph, Missouri

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

DEFINITIONS

For the purpose of these Bylaws, the following definitions shall be used (listed alphabetically):

1. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, mid-level and/or patient care services at the facility. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.

2. Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when serving in the capacity of Acting Facility Director.
3. Associate Director of Patient Care Services (ADPCS): The ADPCS is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he acts as full assistant to the Director in the efficient management of and consultant for clinical and patient care services to eligible patients, the active caretaker of a credentialing and scope of practice system for relevant advanced practice professionals and certain associated health staff, and insurer of 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 Licensed Independent Providers or Mid-Level Practitioners. Associated Health Professionals include, but are not limited to: pharmacists (Clinical Pharmacists and Clinical Pharmacy Specialists), properly qualified registered nurses, licensed audiologists, registered dietitians, licensed social workers, registered physical therapists/occupational therapists, speech therapists/pathologists, qualified addiction counselors, and other allied health professionals who may 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 of clinical care concerns. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care, conduct/behavior issues not impacting patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Medical Executive Board.
6. Chief of Staff: The Chief of Staff is the President of the Medical Staff and Chairperson of the Medical Executive Board 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, Mid-Level Practitioners, and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of the 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. Director (or Facility Director): The Director 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 Medical Executive Board.

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 VA Eastern Kansas Health Care System to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians, dentists, optometrists, podiatrists, and psychologists. It may also include individuals who can practice independently, who meet this criterion for independent practice.

    ***NOTE**: The Full Practice Authority (FPA; passed January 14, 2017) permits VA-appointed (e.g., full-time, part-time, intermittent, WOC) Advanced Practice Registered Nurses to practice as Licensed Independent Practitioners, regardless of state licensure held, and will practice and be privileged as such if approved by both the facility's Organized Medical Staff and Governance, as well as documented in the facility's Medical Staff Bylaws.*

11. Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the medical staff process who are subject to the Medical Staff bylaws. This body may include others, such as retired Practitioners who no longer practice in the organization but wish to continue their membership in the body. The medical staff includes both members of the organized Medical Staff and non-members of the organized medical staff who provide health care services.

12. Mid-Level Practitioner: Mid-Level Practitioners are those health care professionals who are not identified as Licensed Independent Providers (LIP)s or Associated Health Professionals and who, most often will, function within a Scope of Practice but may practice independently on defined clinical privileges as defined in these Bylaws. Mid-Level Practitioners include: physician assistants (PA), Clinical Pharmacy Specialists, and at this facility any Advanced Registered Nurses and Certified Registered Nurse Anesthetists without a VA appointment. Mid-Level Practitioners' scope of practice is limited by the privileges granted and the restrictions of their state of licensure or registration. Furthermore, each Mid-Level Practitioner has a scope of practice based on qualifications and current competence, recommended by the individual's supervising providers, Service Line Manager (SLM), Professional Standards Board (PSB), Medical Executive Board (MEB), and appointed by the facility Director. Mid-Level Practitioners 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. Unless privileged to do so, Advanced

Practice Professionals do not have admitting authority. Advanced Practice Professionals may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations.

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 independent of medical facility, however; oversight is assigned to a medical facility.

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

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

17. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe (i.e., exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision).

18. Professional Standards Board: The Professional Standards Board, if established, may act on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matter to the Executive Committee of the Medical Staff as defined in these Bylaws. This board also may act on matters involving Associated Health and Mid-Level Practitioners~~, and~~ such as granting prescriptive authority, scope of practice, and appointment.

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 MEB and without adoption by the Medical Staff as a whole. Such changes shall become effective when approved by the Director.

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

21. Telemedicine: The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.

22. VA Regulations: The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws. (e.g., 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, Eastern Kansas Health Care System.

ARTICLE II. **PURPOSE**

The purposes of the Medical Staff shall be to:

1. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.
3. Establish and assure adherence to ethical standards of professional practice and conduct.
4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the MEB 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 MEB.
9. Assist the MEB to 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. Assist to 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. Assist to provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.

***NOTE**: VAEKHCS Administration will provide necessary logistical and administrative support in pursuit of these purposes.*

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 3.01 Eligibility for Membership on the Medical Staff

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent Licensed Independent Practitioners who are in good standing who continuously meet the qualifications, standards, and requirements of VHA, this Facility, and these Bylaws.

   ***NOTE**: Please refer to VHA Handbook 1400.1, Resident Supervision for further information regarding Graduate Medical Education and resident supervision.*

2. Categories of the Medical Staff:
   a. Active
      i) Licensed Independent Practitioners (voting)

      ***NOTE**: Active designation also includes part-time practitioners (regular or intermittent part-time). The exception afforded to part-time providers includes non-mandatory participation in the organized meetings of the Medical Staff.*

   b. Associate (non-voting)
      i) Associated Health Professionals
      ii) Mid-Level Practitioners
   c. Without Compensation (non-voting)
   d. Contractor providers, locum providers, fee basis providers, all other associated providers (non-members, non-voting)
3. Decisions regarding Medical Staff membership are made without discrimination for reasons such as race, color, religion, national origin, gender, sexual orientation, lawful partisan political affiliation, marital status, physical or mental handicap when the individual is qualified to do the work, age, membership or non-membership in a labor organization, or on the basis of any other criteria unrelated to professional qualifications.

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

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

a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required by VA employment and utilization policies and procedures.

b. Education applicable to individual Medical Staff members as defined, for example holding a Professional degree from an appropriate professional school.

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 eligibility/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 valid picture ID issued by a state or federal agency (e.g. driver's license or passport).

2. Clinical Privileges and Scope of Practice: While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent Practitioners are permitted by this Facility and these Bylaws to practice independently. All Practitioners listed below are subject to the bylaws whether they are granted defined clinical privileges or not.

   a. The following Practitioners will be credentialed and privileged to practice independently:

      i) Physicians

      ii) Dentists

      iii) Advanced Practice Nurses including contract staff (e.g., CNP, CNM, and CNS) with a VA appointment

      iv) Certified Registered Nurse Anesthetists (CRNA) with a VA appointment

      v) Psychologists

      vi) Podiatrists

vii) Optometrists

viii) Chiropractors

b. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:

i) Audiologists

ii) Speech Pathologists

c. The following Practitioners will be credentialed through the Medical Staff process, including re-credentialing, and will practice under a Scope of Practice with appropriate supervision:

i) Physician Assistants

ii) Clinical Pharmacy Specialists

iii) Contract APRNs who do not hold a VA appointment

iv) Contract CRNAs who do not hold a VA appointment

d. The following Practitioners will practice under a Scope of Practice and may require appropriate supervision:

i) Clinical pharmacists

ii) Registered nurses

iii) Registered dietitians

iv) Licensed clinical social workers

v) Registered physical therapists

vi) Registered occupational therapists

vii) Qualified addiction counselors

viii) Other allied health professionals

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, or professional organization or society membership 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, 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 providers, 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 Board into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action.

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

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

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

Section 3.04 Conflict Resolution & Management

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

NOTE: *Conflict Resolution & Management is further directed by 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. Composition:
   a. Chief of Staff.
2. Selection: The Chief of Staff is assigned to be the leader of the Medical Staff by the Health System Director.
3. Duties:
   a. Chief of Staff serves as Chairperson of the Medical Executive Board (MEB).

Section 4.02 Leadership

1. The Organized Medical Staff, through its committees and Service Line Managers, 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 Line Manager.
   b. Clinical Services hold service-level meetings no less than 9 times per year, or more frequently at the discretion of the Service Line Manager (SLM).
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 a quarterly 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 MEB.

3. Selection and Appointment of Service Line Managers: Service Line Managers are appointed by the Director based upon the recommendation of the Chief of Staff. SLMs who are physicians must be certified by the appropriate medical specialty board.

   NOTE: *Please refer to VHA Handbook 5005, Staffing, for further information regarding how the search is to be conducted, how each candidate's qualifications are reviewed, and how recommendations are made to the Chief of Staff as to the quality of each applicant. Criteria for appointment as Service Chief include Board Certification/or equivalent experience and comparable training as vetted through the credentialing process.*

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

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

   b. Clinically related activities of the Service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 51% of a committee's members will constitute a quorum.
4. The members of all standing committees, other than the Medical Executive Board are appointed by the Chief of Staff subject to approval by the Medical Executive Board, unless otherwise stated in these Bylaws.
5. Unless otherwise set forth in these Bylaws or the respective committee charter, the Chair of each committee is appointed by the Chief of Staff.
6. Robert's Rules of Order Newly Revised will govern all committee meetings.

Section 5.02 Executive Committee of the Medical Staff

1. Characteristics: The Medical Staff Executive Board (MEB) functions as the discussion making body of the Medical Staff. The MEB approves and amends medical staff bylaws and provides continuing oversight for the quality of care, access

to care, and services provided by practitioners with privileges. They are responsible for adopting and implementing medical staff policies and procedures.

The MEB is empowered to act for the medical staff in the time period between medical staff meetings, and coordinate all activities and policies of the medical staff, its departments and committees. They receive and act upon committee reports and make recommendations, where appropriate, to the Executive Committee of the Joint Leadership Council pursuant to the Medical Staff Bylaws.

***NOTE**: Please refer to MEB committee charter located on EKHCS MEB Sharepoint https://vaww.visn15.portal.va.gov/ekh/SiteDirectory/meb/default.aspx*

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 Mid-Level 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:

   ***NOTE**: Please refer to committee charters located on EKHCS MEB Sharepoint https://vaww.visn15.portal.va.gov/ekh/SiteDirectory/meb/default.aspx*

   a. Combined Medicine Committee
   b. Geriatrics & Extended Care Committee
   c. Pharmacy & Therapeutics Committee
   d. Bylaws & Accreditation Committee
   e. Research & Development Committee
   f. Medical Risk Committee
   g. Radiology Committee
   h. Surgery & Surgical Specialty Committee
   i. Behavioral Health Committee
   j. Infection Control & Prevention Committee
   k. Women Veterans Program Steering Committee
   l. Residency Review Committee
   m. Continued Medical Education Committee
   n. Professional Standards Board

o. Medical Records Committee

p. Peer Review Committee

q. Telehealth Oversight Committee

r. Social Work Service Committee

2. Information Flow to MEB: All Medical Staff Committees, including but not limited to those listed above, will submit minutes of all meetings to the MEB in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the MEB.

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 MEB a synopsis of any subcommittee and/or workgroup findings.

Section 5.05 Establishment of Committees

1. The Medical Executive Board may, by resolution and upon approval of the Director, without amendment of these Bylaws, establish additional standing or special committees to perform one or more Medical Staff functions.
2. The Medical Executive Board 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 no less than once per year, or at the discretion of the Chief of Staff or Facility Director. 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 MEB. 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% of the total membership of the Medical Staff membership entitled to vote constitutes a quorum.

4. Meeting Attendance: Members of the Organized Medical Staff are required to attend 100% of regular Medical Staff meetings. Attendance must be tracked and evaluated at reappointment.

ARTICLE VII. **APPOINTMENT AND ONGOING CREDENTIALING**

***NOTE**: Please refer to the following primary resource for supporting information of appointment and ongoing credentialing processes: VHA Handbook 1100.19 http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2910*

Please refer to the following resource for additional facility-specific information: https://vaww.visn15.portal.va.gov/ekh/Docs/Hospital%20Policies/Credentialing%20and%20Privileging%20of%20Licensed%20Independent%20Practitioners%20and%20MidLevel%20Providers.docx

1. Independent Entity: VAEKHCS is an independent entity, granting privileges to the Medical Staff through the MEB and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Mid-Level Practitioner, and Associated Health Practitioner reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff, Mid-Level, and Associated Health Practitioners must practice under their privileges or scope of practice.
2. Credentials Review: All Licensed Independent Practitioners (LIP), Mid-Level, and Associated Health Practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. 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 MEB for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.
   c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.

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

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

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

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

5. Initial Focused Professional Practice Evaluation:

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

      i) Criteria for conducting performance monitoring.

      ii) Method for establishing a monitoring plan specific to the requested privilege.

      iii) Method for determining the duration of the performance monitoring.

      iv) 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:

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

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

6. 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. The maintenance of certification is not sufficient in and of itself. Each service chief must document activities such as direct observation, clinical discussions, and clinical pertinence reviews for ongoing monitoring processes. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk-adjusted where appropriate.

i.) The timeframe for ongoing monitoring is to be defined by Service Line Managers (SLM). SLM must demonstrate that relevant practitioner data is reviewed on regular bases (i.e., no less than every 6 months). Consideration may be based on a period of time or a specified number of procedures and may consider high risk or high volume for an adjustment to the frequency.

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. 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 predefined facility triggers or de-identified quality management data.

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

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

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 7.01 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. Details of credentialing are in VHA Handbook 1100.19.

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

   i) Active, Current, Full, and Unrestricted License: *In instances where Practitioners have multiple licenses, inquiry must be made for all licenses, and the process as noted in VHA Handbook 1100.19 must be followed for each license (38USC 7402). Limitations defined by state licensing authorities must also be considered when considering whether licensure requirements are met.*

   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.

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

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

c. References: The names and addresses of a minimum of four individuals who are qualified to provide authoritative information regarding training/experience, competence, health status, and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer or, for individuals completing a residency, one reference must come from the residency training program director. 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. DEA/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, or 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) Proactive Disclosure Service and the Healthcare Integrity and Protection Data Bank 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 will be obtained from the State licensing board for all actions related to the disciplinary alert, and a statement from the Practitioner will be required.

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

j. Evidence and verification of the status of any alleged or confirmed malpractice.

NOTE: *It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the Practitioner, requesting all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the Practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint. Questions concerning applicants, who may qualify for appointment under the Rehabilitation Act of 1974, need to be referred to Regional Counsel.*

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

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

4. Burden of Proof: The applicant has the burden of obtaining and producing all needed information for a proper evaluation of 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 in *VHA Handbook 1100.19*.

Section 7.02 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: In order to ensure an appropriate review is completed in the credentialing process, the applicant's file must be submitted to the VISN Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the MEB if the response from the NPDB-HIPDB query indicates that any of the following criteria is met: there have been, for or on behalf of the applicant, (a) three or more medical malpractice

payments, (b) a single medical malpractice payment of $550,000 or more, or (c) two medical malpractice payments totaling $1,000,000 or more. The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Chief's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

3. MEB Recommendation: MEB, at the direction of the PSB subcommittee, 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 work days of receipt of a fully complete application, including all required verifications, references and recommendations from the appropriate Service Chief and MEB.

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 the application will be returned due to inadequate information.

Section 7.03 Credentials Evaluation and Maintenance

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

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

   NOTE: *Verification of licensure is excluded from good faith effort in lieu of verification.*

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

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

   a. 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 Line Manager.

   c. A FPPE initiated by a "for-cause" event will be set by the Service Line Manager. 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 Line Manager 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 Line Manager:

      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 7.04 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

***NOTE**: Please refer to the following primary resource for supporting information of appointment and ongoing credentialing processes: VHA Handbook 1100.19 http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2910*

Please refer to the following resource for additional facility-specific information: https://vaww.visn15.portal.va.gov/ekh/Docs/Hospital%20Policies/Credentialing%20and%20Privileging%20of%20Licensed%20Independent%20Practitioners%20and%20MidLevel%20Providers.docx

Section 8.01 General Provisions

1. Clinical privileges are granted for a period of no more than two (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 documentation of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements. Evidence of formal documentation may be requested of the provider.
   c. For initial and reappointment, all time-limited credentials, including peer appraisals, must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Medical Executive Board. 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 Line Manager.

4. Associated Health and Mid-Level Practitioners 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 Line Managers 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 Line Manager.
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. Tele-consultation: All Practitioners providing tele-consultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging, and related VISN policies.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

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

c. Evidence of professional training and experience in support of privileges requested.

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

e. A statement of the current status of all licenses and certifications held.

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

g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.

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

i. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association.

4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.

5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that he/she has received a copy of Sedation and Analgesia by Non-Anesthesia Providers policy and agree to the guidelines outlined in the policy.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

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

   a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic re-credentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Line Manager 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 provider acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Medical Executive Board.

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

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

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

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

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

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

a. Current and previously held licenses in all states.

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

c. NPDB-HIPDB PDS Registration.

d. FSMB query.

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

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

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

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges

1. A Practitioner's request for modification or accretion of or addition to existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Line Manager. This request will initiate the re-credentialing process as noted in the VHA Handbook 1100.19.
2. Primary source verification is conducted if applicable (e.g., provider attests to additional training).
3. Current NPDB-HIPDB PDS Registration prior to rendering a decision.
4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Medical Executive Board 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 Line Manager where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.
   a. Recommendations for initial, renewal, or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references, and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:
      i) Medical/Clinical Knowledge
      ii) Interpersonal and Communication Skills
      iii) Professionalism
      iv) Patient Care
      v) Practice-based Learning & Improvement
      vi) 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, medication usage evaluation, medical record review, blood usage review, medication use review,

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

3. Medical Executive Board, 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 MEB can make the initial review and recommendation, but this information must be reviewed and approved by the MEB.
4. Clinical privileges are acted upon by the Director within 30 calendar days of receipt of the MEB 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.

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

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 by the facility Director or Acting Director at the time of a temporary appointment with the completion of the appropriate credentialing as defined below. Such privileges must be based on documentation of a current state license and other reasonable, reliable information concerning training and current competence. Temporary appointments are for emergent or urgent patient care needs only and will not be used for administrative convenience.
2. The recommendation for temporary privileges must be made by a quorum of the Medical Executive Board and approved by the facility Director. Temporary privileges are not to exceed 60 calendar days.
3. Temporary Medical Staff appointments for urgent patient care needs may require appointment before full credentialing information has been received. Since credentialing is a key component in any patient safety program, the appointment of practitioners with less than complete credentials packages warrants serious consideration and thorough review of the available information.
4. Criteria for consideration for the use of Temporary Privileges for Urgent Patient Care Needs:
   a. A practitioner becomes ill or is placed on a leave of absence, and a provider would need to cover the absent practitioner's practice until the absent provider returns, and/or

b. A specific LIP with specific skill is needed to augment the care to a patient that the patient's current privileged practitioner does not possess.

5. When there is an emergent or urgent patient care need, a temporary appointment may be made, in accordance with VHA Handbook 5005, Part II, by the facility Director prior to receipt of references or verification of other information and action by a Professional Standards Board.
   a. Minimum required evidence includes:
      i) Verification of at least one active, current, unrestricted license with no previous or pending actions;
      ii) Confirmation of current comparable clinical privileges;
      iii) Response from NPDB-HIPDB CQ registration with documentation of no match;
      iv) Query of licensure history through the FSMB Physician Data Center with no adverse action reports documented; and
      v) Receipt of at least one peer reference who is knowledgeable of and confirms the practitioner's competence and who has reason to know the individual's professional qualifications.
6. In those cases were an application is completed prior to the Temporary Appointment for Urgent Patient Care Needs, it must be a "clean" application with no current or previously successful challenges to licensure; no history of involuntary termination of medical staff membership at another organization; no voluntary limitation, reduction, denial, or loss of clinical privileges; and no final judgment adverse to the applicant in a professional liability action.
7. Temporary appointments must be completed in VetPro, including the NPDB-HIPDB CQ registration and response and the FSMP query and response. These appointments may not be renewed or repeated.
8. An application through VetPro must be completed within three calendar days of the date the appointment is effective.
   a. This includes:
      i) Supplemental Attestation Questions, a Declaration of Health, and a Release of Information.
   b. This additional information will facilitate the required completion of the practitioner credentialing for these practitioners used in Urgent Patient Care Needs situations as well as providing additional information for evaluation of the current Temporary Appointment and reducing any potential risk to patients.
9. If the Temporary Appointment is not converted to another form of Medical Staff appointment, complete credentialing must be completed even if completion occurs after the practitioner's temporary appointment is terminated or expires.
   a. At a minimum, the practitioner must submit a VetPro application, and all credentials must be verified.

b. If unfavorable information was discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

10. Emergency or Disaster Privileges: Disaster privileges may be granted when the facility has activated the Emergency Operations Plan under the Incident Command System (ICS) and the facility is unable to handle the immediate patient needs.

a. Disaster privileges will be granted by the Chief of Staff or designee and that individual will discuss the need with the Incident Commander.

b. At a minimum, 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 practitioners will be distinguished from those currently appointed at the facility.

iv) A description for oversight of the performance of volunteer practitioners who are granted disaster privileges.

v) A description of the mechanism to manage the activities of the practitioners 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 which disaster privileges are granted, which must include:

(1) A current hospital photo identification card and evidence of current license to practice, or

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

(3) 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.

c. The facility Chief of Staff or designee will determine within 72 hours of the practitioner's arrival if granted disaster privileges should continue based on its oversight of the practitioner. Privileges can be renewed at any time by decision of the Chief of Staff, designees, or Incident Commander.

d. 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.

i) 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.

e. The period under which professionals granted disaster privileges may practice will not exceed 10 calendar days or the length of the declared disaster, whichever is shorter.

i) At the end of this period, the practitioner needs to be converted to Temporary Privileges defined by the current Bylaws.

f. As soon as the immediate emergency is under control and/or ICS has been stood down, the verification process of the credentials and privileges of health care professionals who receive disaster privileges will begin.

i) This process will be identical to the process for granting Temporary Privileges and may ultimately result in complete credentialing of these practitioners.

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

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

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

12. 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 possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment.

***NOTE**: No step in this process should be a barrier in preventing the Practitioner from returning to the Facility in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.*

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 Medical Executive Board for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the Medical Executive Board 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 Line Manager, 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. 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-HIPDB PDS 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.

ARTICLE IX. **INVESTIGATION AND ACTION**

1. Request for Investigation: Whenever the behaviors, activities, and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be

detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Behavior or Behaviors That Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff, or the Facility Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct which constitutes the grounds for the request. The Chief of Staff promptly notifies the Director in writing of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process.

***NOTE**: If the person under review is an employee, then the processes must also follow VA Directive 5021 - Management of Employees (Appendix A pages 2-9).*

2. Fact Finding Process: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article IX, a fact-finding process will be implemented. This fact-finding process should be completed within 30 calendar days or there needs to be documentation as to why that was not possible. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities, and/or professional conduct of the Practitioner are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Behavior or Behaviors That Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, the Director may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the Professional Standards Board.
3. Review by Professional Standards Board: The Professional Standards Board (PSB) investigates the charges and makes a report of the investigation to the Medical Executive Board (MEB) within 30 calendar days after the PSB has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the PSB to discuss, explain, or refute the charges against him/her. This proceeding does not constitute a Hearing, and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation by the PSB is an administrative matter and not an adversarial Hearing. A record of such proceeding is made and included with the committee's findings, conclusions, and recommendations reported to the MEB.
4. MEB Action: Within 14 calendar days after receipt of a report from the PSB, the MEB acts upon the request. If the action being considered by the MEB involves a

reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the MEB prior to the committee's action on such request. This proceeding does not constitute a Hearing, and none of the procedural rules set forth in Article X of these Bylaws apply thereto. A record of such proceeding is made by the MEB.

a. The MEB may reject or modify the recommendations; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension, or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified, or sustained; or recommend that the Practitioner's staff membership be suspended or revoked.

b. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

c. Reduction of privileges may include, but not be limited to, functioning under supervision, restricting performance of specific procedures or prescribing, and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition such as demonstration of recovery from a medically disabling condition or further training in a particular area.

d. Revocation of privileges refers to the permanent loss of clinical privileges.

5. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, the entirety or portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by Facility Director.

   a. The Chief of Staff convenes the PSB to investigate the matter, meet with the Practitioner if requested, and make a report thereof to the MEB within 14 calendar days after the effective date of the Summary Suspension.

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

6. Automatic Suspension of Privileges: An Automatic Suspension occurs immediately upon the occurrence of specific events. The scope of Automatic Suspension will be dependent on the nature of the restriction, limitation, probation, suspension, or revocation and will be effective upon, and for at least the term of the restriction, limitation, probation, suspension, or revocation; however, those with limitations or restrictions placed on their license may continue to hold Membership if recommended by the MEC and approved by the Board. The MEC may recommend such further Corrective Action as is appropriate to facts disclosed by investigation.

a. The Medical Staff membership and clinical privileges of any Practitioner with delineated clinical privileges shall be automatically suspended if any of the following occurs:

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

   ii) Failure on the part of any staff member to complete medical records in accordance with system policy will result in progressive disciplinary action to possible indefinite suspension.

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

   iv) Failure to maintain the mandatory requirements for membership to the Medical Staff.

   v) The Practitioner is being investigated for conduct/behavior issues not impacting patient care.

b. The Chief of Staff convenes the PSB to investigate the matter and make a report thereof to the MEB within 14 days after the effective date of the Automatic Suspension.

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

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

7. Actions Not Constituting Corrective Action: The PSB will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:

   a. The appointment of an ad hoc investigation committee;

   b. The conduct of an investigation into any matter;

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

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

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

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

g. Corrective counseling;

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

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

ARTICLE X. **FAIR HEARING AND APPELLATE REVIEW**

1. Reduction of Privileges:

   a. Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

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

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

   b. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff's written notice of intent. The Practitioner must submit a response within 10 workdays of the Chief of Staff's written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed 10 additional workdays except in extraordinary circumstances.

   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 5 workdays after receipt of decision of the Director.

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

2. Convening a Panel: The facility Director must appoint a review panel of three unbiased professionals, within 5 workdays after receipt of the Practitioner's request for hearing. These three professionals will conduct a review and hearing. At least two members of the panel must be members of the same profession as the Practitioner. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty as the Practitioner. This review panel hearing is the only hearing process conducted in connection with the reduction of

privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

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

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

   i) Be present throughout the evidentiary proceedings.

   ii) Be represented by an attorney or other representative of the Practitioner's choice.

   NOTE: *If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses.*

   iii) Cross-examine witnesses.

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

3. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.

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

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

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

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

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

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

5. 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.

6. The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, to cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

   NOTE: *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, or does so or in return for not conducting such investigation, such action is reported to the NPDB and the appropriate state licensing boards without further review or due process.*

7. Revocation of Privileges:

   a. Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures.

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

ii) For probationary employees appointed under 38 U.S.C. 7401(1) and 38 U.S.C. 7405, the proposed revocation will be combined with probationary separation procedures, which constitutes an automatic revocation as contained in VA Handbook 5021 Employee/Management Relations.

b. Revocation procedures will be conducted in a timely fashion. If discharge, separation during probation, or termination of appointment is not proposed, revocation of clinical privileges may not occur. Even though a revocation of privileges requires removal from both employment and appointment to the Medical Staff, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. For example, a surgeon's privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

8. Reporting to the National Practitioner Data Bank (NPDB):

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 (i.e., Regional Counsel, General Counsel, U.S. Attorney) investigate 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 providers 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 Practitioners 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.

9. 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.

10. 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 facility Director, on the recommendation of the Chief of Staff, may summarily suspend privileges on a temporary basis when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

ARTICLE XI. **RULES**

The Medical Staff shall adopt such Rules and as may be necessary to implement more specifically the general principles found within these Bylaws and in the guidelines of the Governing Body 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. Such Rules shall be subject to approval of the Director. Such Rules shall be a part of these Bylaws. The Rules may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Executive Board. The proposed Rule change shall then be submitted electronically for a 30 day review by the entire Medical Staff. Any submitted comments from this review shall then be presented to the MEB at their next meeting, at which time the Rule will become in effect with a majority vote of the MEB providing a quorum is present and with subsequent approval of the Director.

Anything in these Rules that contradicts a VA Directive or Handbook is superseded by that Directive or Handbook.

ARTICLE XII. **AMENDMENTS**

1. The Bylaws and Rules of the Medical Staff will be 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 the last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff or recommendation from the MEB. All proposed changes to the Bylaws of the Medical Staff shall be submitted in meeting or electronically by the Chief of Staff to the Bylaws Committee for review, discussion, comment, and approval. Recommended actions are then submitted to the MEB for final approval. Amendments approved by a majority of the MEB in a meeting with a quorum present will then be submitted electronically for review by the entire Medical Staff at least 30 days prior to the next called meeting of the Medical Staff.

2. Notice of the date and time of the Medical Staff meeting, shall be provided to members at least 30 days before formal consideration in a Medical Staff meeting.

3. If an amendment proposed is in conflict with the current Bylaws or other known regulations of the Governing Body, the chairperson of the Bylaws Committee will make suggestions that would eliminate the conflict.

4. The proposed amendment will be voted at the called meeting of the Medical Staff referenced in paragraph 2. above. To be adopted, an amendment will require a simple majority vote of the active Medical Staff present providing there is a quorum present at the meeting. Amendments so made shall become effective when approved by the Director.

5. All changes to the Bylaws of the Medical Staff require action by both the Medical Staff and the Director. Neither the Medical Staff nor the Director shall act unilaterally.

6. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEB may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MEB. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the MEB, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEB is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

ARTICLE XIII. **ADOPTION AND SIGNATURES**

These *Bylaws*, together with the appended Rules, shall be adopted upon recommendation of the Medical Staff and shall replace any previous *Bylaws and Rules of the Medical Staff.* They shall become effective when approved by the Director of VAEKHCS.

Adopted by the Medical Staff of the VA Eastern Kansas Health Care System on this 22nd day of June 2016.

RECOMMENDED

ALEXANDER HALLOCK, MD, FACP — Date 8/8/17.

Chief of Staff, EKHCS

APPROVED

A. RUDY KLOPFER, FACHE, VHA-CM — Date 8/9/2017

Director, EKHCS

MEDICAL STAFF RULES

GENERAL

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

Rules of service lines, departments, or services shall not conflict with each other, with the *Bylaws and Rules of the Medical Staff*, with other policies of VAEKHCS, or with requirements of the Governing Body. Any conflicts shall be resolved by the Chief of Staff and/or the Medical Executive Board (MEB).

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

1. PATIENT RIGHTS

***NOTE**: Please refer to the following resource when considering changes to this section: 38CFR17.33-1, https://www.gpo.gov/fdsys/granule/CFR-2012-title38-vol1/CFR-2012-title38-vol1-part17*

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

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

c. Collaboration with the provider in matters regarding personal health care.

d. Pain management including assessment, treatment, and education.

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

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

g. 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.

h. Access to information about patient rights and handling of patient complaints.

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

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

k. Personal privacy and confidentiality of information.

l. 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 provider to be medically incapable of understanding treatment or unable to communicate his/her wishes.

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

n. Foregoing or withdrawing life-sustaining treatment including resuscitation.

o. Nondiscrimination against individuals who use or misuse alcohol or other drugs and persons infected with the human immunodeficiency virus.

Living Will, Advance Directives, and Informed Consent

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

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

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

d. Competent patients will be encouraged, but not compelled, to involve family members in the decision-making process. Patient requests that family members not be involved in or informed of decisions concerning life-sustaining treatment will be honored and will be documented in the medical record.

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

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

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

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

iii. 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 provider agree that the withholding or withdrawal of life-sustaining

treatment would be in the patient's best interests. In cases where the attending provider 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 provider 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.

2. GENERAL RESPONSIBILITY FOR CARE

a. Responsibility for the Conduct of Care

Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff. The provider 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 other diagnostic tests, 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.

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 provider, a maxillofacial surgeon, or other qualified licensed individual in accordance with state law, as well as 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.

b. Admissions

VAEKHCS shall admit legally-eligible persons, as defined by law and applicable VA regulations, suffering from any type of disease or injury which, in the opinion of the admitting medical professional, should and can be treated on an inpatient basis at the VAEKHCS, or should be admitted for humanitarian reasons until the patient may be transferred to a health care facility equipped to care for the disease or injury.

c. Requirement for Provisional Diagnosis

Except in an emergency, no patient shall be admitted to either of the medical centers in VAEKHCS until a provisional diagnosis has been documented in the

medical record. Medical Staff members will examine and make the proper disposition of all eligible applicants.

d. Humanitarian Admission

Under emergency conditions or for humanitarian reasons, any person may be admitted on a temporary basis. The duration of such hospitalization shall be determined by the appropriate SLM or Chief of Staff, with concurrence by the VAEKHCS Director.

e. Admitting Rights

i. Provider members of the Medical Staff may admit patients for inpatient care. Resident physicians (trainees) may admit patients for inpatient care under the supervision of a provider member of the Medical Staff. Other members of the Medical Staff (such as dentists, podiatrists, optometrists or psychologists) and Mid-Level practitioners may admit patients if admission is approved by a provider on the Medical Staff and if required aspects of inpatient care are provided/overseen by a provider on the Medical Staff. Only licensed providers and dentists may reject patients for medical care. All medical and medical specialty admissions are routed through the hospitalist. If an admission is deemed inappropriate by a service after arrival on the unit, the admission will not be canceled. The patient will be transferred to an appropriate service or discharged to an outpatient treatment status if eligible.

ii. All patients will be attended by members of the Medical Staff who have clinical privileges for the treatment of the type of condition that requires hospitalization.

iii. Each practitioner is held responsible for the medical aspects of a patient assigned and will not delegate or transfer this responsibility to another practitioner who is not qualified for this undertaking.

iv. The Medical Staff in attendance will maintain a complete, current, and legible medical record for each patient. The medical record will include identification data, chief complaint, past medical history, family history, history of present illness, physical examination, special reports, progress notes, provisional diagnosis(es), final diagnosis(es), and a discharge summary which includes the condition of the patient at the time of discharge and a plan for continued care of the patient.

v. Any direct medical care provided to patients by members of the house staff (resident physician trainees) or by allied health personnel will be supervised by the licensed provider assigned responsibility for the care of the patient.

f. History and Physical Examination

i. A history and physical examination (H&P) that includes: 1) present and past medical history, 2) family history, 3) social history to include military (if not

previously documented) and occupational history, 4) inventory of body systems, 5) physical examination, and 6) initial plan of care including provisional diagnoses shall be performed and documented by an LIP or PA within 24 hours of admission of the patient to an inpatient unit. In Psychiatry, this will include a psychiatric history.

ii. In the Community Living Center (CLC) or other units surveyed for accreditation under the JC Long Term Care standards, the history and physical examination will be performed and documented within 72 hours of admission of the patient.

iii. In the Domiciliary or other residential programs that are surveyed under the Joint Commission standards for Behavioral Health, the history and physical examinations will be performed and documented within 7 calendar days of admission.

iv. In those instances when a patient is admitted within 30 days following the date of the latest prior complete H&P (performed on an inpatient or outpatient basis), an interval H&P reflecting any subsequent changes may be used in the medical record. This is permitted if it is medically determined that such an exam, in conjunction with the prior exam, is adequate to reflect a comprehensive and current physical examination. An interval history and physical exam, when used, will be entered in a progress note and will contain the following:

   a. A statement that the previous history has been reviewed and a physical performed.
   b. Pertinent changes to the history/and physical will be specified.
   c. If there is no change noted in the history and physical examination, it will be so stated.

v. In all cases where surgery is performed, the medical record will show documentation of a complete H&P performed within the past 30 days or an interval H&P progress note, as described above. The requirement for H&P for certain minor or simple surgical and medical procedures has been waived. A list of these procedures is available from the office of the COS. For cases where the H&P examination is required, this documentation must be in the medical record prior to the surgical operation or procedure. In an emergency, when there is no time to record the complete H&P, a note on the preoperative diagnosis is recorded before surgery.

g. <u>History and Physical Examination by Practitioners other than Medical Staff</u>

i. Medical and psychiatric histories, physical examinations, and system reviews may be accomplished by qualified individuals other than members of the Medical Staff (e.g., resident physician trainees, Mid-Level Practitioners) when such responsibilities are defined in the individual's scope of practice. The

provider assigned responsibility for the care of the patient must review such H&Ps. An appropriate entry indicating review and concurrence (or differences) must be made by the provider in the medical record as soon as possible. Concurrence in the medical record prior to any major diagnostic or therapeutic intervention is required. Any difference will be documented by amending and co-signing the H&P.

ii. Other components of an inpatient assessment may include a history of and screening for substance abuse, mental status exam or screening, military history, and psychosocial history. Providers and other qualified professionals (when defined in their scope of practice, functional statement, or position description) may perform these duties. In a substance abuse treatment program, qualified addiction therapists may perform and document history-taking/screening for substance abuse, mental status exam or screening, military history, and psychosocial history if these duties are identified in their position descriptions and defined in protocols approved by the MEB. These medical record entries by qualified addiction therapists will not require co-signature by the patient's provider.

iii. Qualified podiatrist and dentist members of the Medical Staff are responsible for completing the parts of H&P that relate to podiatry and dentistry, respectively. Qualified oral surgeon members of the Medical Staff who admit patients without medical problems may perform the H&P on these patients if they have such privileges and may assess the medical risks of the proposed surgical procedure.

h. Laboratory and Radiology Examination

Each patient admitted to inpatient care shall have appropriate laboratory and x-ray examinations in accordance with the current standards of care in the particular area of medical practice. When ordering diagnostic examinations, the practitioner shall provide adequate and pertinent information. Each Service Line with inpatient beds may specify in its policy and procedures manual the examinations that are to be routinely obtained on patients admitted to the Service Line.

i. HIV Counseling

See HSPM 11-10 Human Immunodeficiency Virus (HIV) Diagnostic Testing.

j. Intensive Care Unit(s) (ICU)

Admission of patients to the Intensive Care Unit(s) (ICU), based on medical or surgical need for this level of care, is restricted to qualified providers in Medicine or Surgery Service Lines who have been recommended by the provider(s) in charge of the ICU(s) and approved by the MEB. Specific admission criteria to the ICU are found in the ICU policies.

3. MULTIDISCIPLINARY TREATMENT PLANNING

When a team approach is used in the treatment of a patient, the areas of responsibility and authority, together with the functional roles of the multidisciplinary team, shall be documented and approved by the SLM. Even though authority to perform certain acts may be delegated to various team members, the ultimate responsibility for diagnosis and treatment of a patient remains with the provider, and written policies of the Service Line outline appropriate provider involvement in and approval of the multidisciplinary treatment plan.

4. TRANSFERS

a. Transfer to or from a non-VA Medical Center or another VA Facility

i. Patients will not be transferred arbitrarily. Rather, patients will be transferred in accordance with good clinical practice to an appropriate facility having the services available and necessary for quality treatment.

ii. Patients transferred to another facility for specialized treatment may be returned for continued care when medically indicated. They will not be transferred solely for the purpose of discharge planning.

iii. Patients will not be transferred between facilities until the patient's care has been discussed and documented between the referring and accepting providers.

iv. A medical records entry will document:

a. Reason for transfer
b. Alternatives to transfer
c. Accepting facility
d. Accepting provider
e. Patient/family education about further care and alternatives
f. Patient's physical and psychosocial status
g. Summary of care, treatment, and service provided and progress toward goals
h. Community resources or referrals provided to the patient
i. Accountability and responsibility for patient's safety during transfer

v. Patients medically unstable will not be accepted for transfer into the VAEKHCS. If there is any question as to the safety of the transfer, a patient should be admitted to the facility where he/she has presented until the patient is documented as medically stable for transfer to the VAEKHCS. Medically unstable patients will not be transferred out of the VAEKHCS until such time as their medical condition is safe for transfer unless in the opinion of the treating provider, the benefits of transfer outweigh the risk.

b. Transfers within the Medical Center

i. Patients shall not be transferred from one service line or section, or out of an ICU or from the recovery room, without a written order by the Medical Staff member responsible for the patient's care.

ii. Transfers from one service line to another will be accomplished by the mutual agreement of the service lines involved.

iii. There shall be a transfer note written on the progress notes by the responsible Medical Staff member transferring the patient to another provider's care. It shall be a concise recapitulation of the medical course to date, developed to assist the Medical Staff member who assumes responsibility for the continuity of inpatient Care.

iv. The unit clerk or nursing staff members will be responsible for promptly notifying the responsible receiving staff as soon as the new patient has arrived on the unit.

v. ICU will accept critically ill patients meeting the criteria established by the clinical service lines and the Advisory Committee for Intensive Care, and approved by the MEB. Persons having a DNR order will be maintained or transferred into ICU only when sufficient beds and nursing resources are available. Exceptions can be made by the Medical Director(s) of the ICU(s), the Medicine SLM, or by the Chief of Staff.

5. CONSULTATIONS

a. Good medical judgment should always be exercised in the initiation of consultation requests in order to avoid overburdening the consulting section, department, or individual. Consultations should be requested for valid medical reasons. They should be written clearly, setting forth the problem and the information requested. They may be written by providers, dentists, podiatrists, and optometrist members of the Medical Staff. Mid-Level practitioners and other qualified professionals may request medical consultations when such authority is defined in their scope of practice. Non-medical consultations (e.g., psychological testing, etc.) may be requested by professionals who have this included in their scopes of practice.

b. Psychiatric consultation is required for patients who have attempted suicide or have taken a chemical overdose while on authorized absence or in the hospital.

c. Except in an emergency, consultation with another qualified professional should be considered when, in the judgment of the patient's responsible clinical staff member:

   i) The patient is not a good risk for operation or treatment,

   ii) The diagnosis(es) is obscure,

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

d. A consultant must be well-qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical Staff, based on the individual's training, experience, and competency.

e. The responsibility of determining policy for answering medical consultation requests rests with the clinical SLM and/or clinical supervising provider in the service line sections providing the consultative services. Specific time frames should be identified in service line HSPM. Time frames for responding to consultation requests and documenting consultations in the medical record shall be approved by the MEB and communicated to the Medical Staff. The basic philosophy of the Medical Staff is to provide medical consultation with a high level of professional competency, efficiency, and promptness.

f. A satisfactory consultation includes examination of the patient and the records. A written opinion and recommendation(s) signed by the consultant must be included in the patient's medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

g. Unless otherwise indicated in the requesting practitioner's consultation request, it is assumed that consultants may write orders and/or provide treatment for the patient for whom consultation is requested.

h. Consultation within VAEKHCS does not represent referral or transfer of care.

i. Medical ethics should be followed in consultations. The findings and opinions of the consultant should be limited to the clinicians involved. Patients, their representatives and families should not be apprised or advised by the consultant, except with the attending staff member's prior knowledge and consent.

6. DISCHARGES

a. Discharge Planning

i) Discharge planning in the VAEKHCS is a process by which staff collaborates with the patient and significant others to develop an individualized plan for continuing care. Patients and their families or significant others shall have active involvement in developing the discharge plan whenever possible. The planning and involvement of the patient will be documented in the medical record.

ii) Discharge planning begins as early as a determination of need is made by the evaluation of discharge potential and resources.

iii) The discharge plan shall be designed to assist the patient in reaching his or her optimum activity level and shall address post-hospital adjustment issues, including the services necessary to ensure continuity of care to meet the patient's needs.

iv) Particularly difficult discharge planning problems may require consultation with the SLM or Chief of Staff who may convene a group of professionals to recommend options.

b. Discharges from Inpatient Status

The release of an inpatient from VA hospitalization or Community Living Center depends on the following medical decisions:

i) The patient does not require continued services which are only available to an inpatient, and

ii) All indicated outpatient medical needs, nursing, or home care services are suitably arranged in advance of the patient's release from the VAEKHCS.

iii) Patients who are clinically ready for release but who refuse to accept discharge will be permitted to discuss the reasons with the SLM, Chief of Staff, or their designees. If the reasons provided by the patient are not considered valid and it is clear there are no medical reasons for the patient to remain hospitalized, necessary action will be taken to remove the patient from the facility.

iv) Patients shall be discharged only on written order of a provider or other professional qualified and permitted by clinical privileges or scope of practice

to discharge patients. No discharge will occur without adequate provisions for continued follow-up care.

c. Discharges from Intensive Care Unit

i) Patients having met discharge criteria developed by the Advisory Committee for Intensive Care will be moved from the ICU to the appropriate ward. When ICU beds are unavailable, the Medicine Manager or Medical Director of ICU and the Surgery Manager will designate patients in order of assessed needs for transfer to the wards. The Chief of Staff may be consulted.

d. Discharges from Post-Anesthesia Recovery

i) The release of every patient from the post-anesthesia recovery area shall be in accordance with recovery room policy, i.e. discharged on order of the anesthesiologist or the provider/surgeon caring for the patient. If the anesthesiologist or the provider/surgeon caring for the patient is not available, the patient may be released from the recovery area if his/her clinical condition meets previously approved discharge criteria.

e. Discharge Summary

i) Discharge summaries should be documented prior to discharge if the patient is being transferred to another facility, or within 7 days if discharged to outpatient care, or in cases of death or irregular discharge. Discharge summaries upon death will include the time and date when the patient expired and the events leading to the death must be recorded by the provider.

7. **AUTOPSY**

a. In the interest of improved patient care and professional knowledge, every member of the Medical Staff is expected to actively participate in securing autopsies. Criteria identifying patient categories in which an autopsy should be performed are established by current VA policy and will be followed by the VAEKHCS Medical Staff.

b. Members of the Medical Staff shall be familiar with the laws of the State of Kansas and VA regulations regarding deaths that must be reported to the Coroner. Consent for autopsies will be obtained in accordance with all legal and VA guidelines.

8. DIAGNOSTIC TESTS PERFORMED UNDER SHARING AGREEMENTS

a. When non-invasive diagnostic testing (laboratory studies, radiology and nuclear medicine exams, physiologic testing) are performed pursuant to sharing agreements on the request of providers outside the VAEKHCS Medical Staff, it shall not be necessary to have a member of the Medical Staff as an ordering provider unless they are expected to provide patient care in association with the testing. For purposes of entering the orders for these tests, the outside provider shall be listed as the ordering provider.

9. PROVIDERS' ORDERS

a. General Requirements

i) Orders are entered into the computerized patient record system (CPRS).

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

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

b. Medication Orders

i) All medications 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 Medications that have been approved by the Research and Development Committee and the Facility P&T committee. Exceptions to the foregoing requirements may be made in use of "provisional medications" or "non-formulary medications" 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 medications used in the Facility will be stored and dispensed by the Pharmacy.

iii) Duration of Orders

(1) All prescriptions must be entered electronically.

(2) All prescription controlled substances will follow VHA Handbook 1108-.01.

(3) Schedule II controlled medications will be written for periods not to exceed 14 days for in-patients and must be reentered by electronic entry into EMR for each succeeding period of 14 days or less.

(4) Schedule III – V controlled medications may be written for a period not to exceed 30 days.

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

(6) Orders for all other non-scheduled medications will be written for a period not to exceed 90 days from the date the first medication was ordered before they expire and must be rewritten, unless otherwise specified within specific requirements for treatment using a particular medication.

(7) The number of refills authorized on a single prescription may not, in total, exceed one year.

iv) Domiciliary and Community Living Center Care Medication Orders

(1) All prescriptions must be entered electronically.

(2) In the Domiciliary, for pill line and outpatient orders, controlled substances are limited to a 7-day supply.

(3) In the Community Living Center, Schedule II medications can have a duration of 14 days if specified in the order. Otherwise, the duration is limited to 3 days.

(4) Ninety (90) days is the maximum duration for applicable Community Living Center prescriptions

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 provider of record, orders must be written for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same provider, the existing orders remain valid.

c. Standardized Order Sets (protocols)

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

d. Investigational Medications

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

e. Informed Consent

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

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

f. Submission of Surgical Specimens

i) All tissues and objects except teeth removed at operation shall be sent to the Facility pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

g. Special Treatment Procedures

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

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

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

(3) Documentation in the medical record.

(4) 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 only by those Practitioners with approved and current privileges to do so.

iii) Restraint and Seclusion

(1) Restraint is defined as any method (physical/mechanical device or chemical substance) used to involuntarily restrain the movement of a patient's entire body or a portion of the body for the purpose of protecting the patient or others from physical injury caused by physical activity of the patient. Seclusion is defined as the involuntary confinement of a patient alone in a room in which the patient is physically prevented from leaving for any period of time unattended.

(2) A provider (or other professional with authority granted in his/her scope of practice, functional statement or position description) may order restraint and/or seclusion for a patient when there is actual or substantial risk of serious physical injury to the patient or others, or actual or substantial risk of serious self-destructive behavior. Restraint/seclusion will not be used unless less restrictive interventions have been demonstrated to be ineffective. The use of restraint/seclusion and all related procedures will be in accordance with regulations promulgated by the VA and in accordance with local implementing directives.

10. ROLE OF ATTENDING STAFF

a. Supervision of Residents and Non-Physicians

***NOTE**: Please refer to the following resource when considering changes to this section: Resident Supervision – VHA Handbook 1400.1, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2847*

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) Mid-Level and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

b. Documentation of Supervision of Resident Physicians

i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending provider 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-LIPs (e.g., Mid-Level providers, etc.) that require countersigning by supervisory or attending Medical Staff members are covered by appropriate Facility policy and include:

(1) Medical history and physical examination.

(2) Discharge Summary.

(3) Operative Reports.

(4) Medical orders that require co-signature.

(a) DNR.

(b) Withdrawing or withholding life sustaining procedures.

(c) Certification of brain death.

(d) Research protocols.

(e) Investigational medication 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 provider must either write the order for (1) through (5) above or, in an urgent/emergency situation, the house staff or non-provider must obtain verbal concurrence from the attending, document in the progress notes the discussion and concurrence, and can write and sign the order. The attending Medical*

Staff member must then co-sign the progress note noting the discussion and concurrence within 24 hours.

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

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

11. MEDICAL RECORDS

***NOTE**: For additional information see: Health Information Management and Health Records – 1907.1, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=3088*

a. Basic Administrative Requirements

i) Entries must be electronically entered where possible, the process of which automatically dates, times, and authenticates with method to identify author, and includes written signatures.

ii) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Mid-Level Practitioners.

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

iv) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished per individual service line guidelines.

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

***NOTE**: Please refer to the following resource when considering changes to this section: Privacy & Release of Information Handbook – VHA Handbook 1605.1, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1423*

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 and data contained therein 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. <u>All Medical Records must contain:</u>

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. <u>Inpatient Medical Records</u>

In addition to the items listed in section b. above, all inpatient records must contain at a minimum:

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

ii) A complete physical examination includes (but is not limited to) general appearance, review of body systems, nutritional status, ambulation, self-care, mentation, social history, review of the results of pertinent studies which includes but is 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.

(1) 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.

(2) Inpatient H&P must be completed within 24 hours, 72 hours for long term care, and 7 days for the Domiciliary.

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

iv) Have a discharge summary (from inpatient or Domiciliary) dictated no later than the day of discharge.

v) And all other inpatient medical records completed within 30 days of discharge.

d. Outpatient Medical Records

In addition to 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, and medication 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:

(1) 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, as well as discussion with the patient

and family of risks, benefits, potential complications, and alternatives to planned surgery and signed consent.

(2) 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.

(3) 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.

(4) 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.

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

(a) Pre-operative diagnosis,

(b) Post-operative diagnosis,

(c) Technical procedures used,

(d) Surgeons,

(e) Findings,

(f) Specimens removed, and

(g) Complications.

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

(a) Anesthesia,

(b) Blood loss,

(c) Drains,

(d) Tourniquet Time, or

(e) Plan.

iv) Post-Operative Documentation: An operative report must be dictated and 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:

(1) 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 medications 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.

(2) 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.

(3) 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.

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

12. INFECTION CONTROL

a. Isolation is described in local Infection Control Policy.

b. Standard Precautions are described in local Infection Control Policy.

c. Reportable Cases are described in local Infection Control Policy.

13. CONTINUING EDUCATION

a. 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.

14. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

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

b. Where there is evidence that a provider 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.

c. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the facility's Employee Assistance Program (EAP) in accordance with VHA Handbook 5383, VA Drug-Free Workplace Plan.

d. 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.

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

f. Confidentiality of the Practitioner seeking referral or referred for assistance will be kept, except as limited by law or 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.

g. 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.

15. PEER REVIEW

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.

16. SMOKING POLICY

Smoking policy (2008.05.2) Smoking Policy – VHA Directive 2008-052, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1752;

17. **CPR CERTIFICATION**

Requirements for CPR certification (BLS or ACLS) CPR Policy – VHA Directive 1177, http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3051

18. DISCLOSURE POLICY

Requirements for Disclosure of Adverse Events to Patients Policy – VHA Handbook 1004.08, http://www.ethics.va.gov/Handbook1004-08.pdf

19. QUALITY MANAGEMENT DIRECTIVE

VHA Enterprise Framework for Quality, Safety, and Value – VHA Directive 1026, http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2923

20. TIME AND ATTENDANCE POLICY

EKHCS Absence and Leave Policy, https://vaww.visn15.portal.va.gov/ekh/Docs/Hospital%20Policies/Absence%20and%20Leave%20Policy.docx

21. CODE OF CONDUCT POLICY

EKHCS Employee Code of Conduct, https://vaww.visn15.portal.va.gov/ekh/Docs/Hospital%20Policies/Employee%20Code%20of%20Conduct.docx

22. CONFLICT OF INTEREST POLICY

EKHCS Financial Relationships Between VHA Health Care Professionals and Industry, https://vaww.visn15.portal.va.gov/ekh/Docs/Hospital%20Policies/Financial%20Relationships%20between%20VHA%20Health%20Care%20Professionals%20and%20Industry.docx

23. SUICIDE ASSESSMENT POLICY

EKHCS Identification and Management of the Suicidal and/or Homicidal Individual, https://vaww.visn15.portal.va.gov/ekh/Docs/Hospital%20Policies/Identification%20and%20Management%20of%20the%20Suicidal%20and_or%20Homicidal%20Individual%20(Both%20Outpatients%20and%20Inpatients).docx

Adopted by the Medical Staff, Eastern Kansas Health Care System Leavenworth and Topeka, Kansas, this 22nd day of June 2016.

RECOMMENDED

ALEXANDER HALLOCK, MD, FACP
Chief of Staff, EKHCS

8/8/17
Date

APPROVED

A. RUDY KLOPFER, FACHE, VHA-CM
Director, EKHCS

8/9/2017
Date