



MEDICAL STAFF BYLAWS

Rules and Regulations

Department of Veterans Affairs Medical Center
Kansas City, Missouri

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PREAMBLE AND STATEMENT OF PURPOSE

The Department of Veterans Affairs Medical Center, Kansas City, Missouri, is a public hospital organized under the provisions of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) and serves as a key component of an integrated health care delivery system -- the Heartland Veterans Integrated Service Network (VISN 15) -- in providing patient care, education, and research.

The Undersecretary for Health of the Veterans Health Administration (VHA), Department of Veterans Affairs (VA), Washington, D.C., has delegated authority of the Governing Body to the Medical Center Director for local facility management and planning. The Medical Center Director ("Chief Executive Officer"), upon the advice of the Medical Staff and the Director's Advisory Board, acts as the Governing Body for Department of Veterans Affairs Headquarters

Recognizing that the Medical Staff is responsible for the oversight of care, treatment, and services delivered by its members and accountable to the Director for all aspects of that care, the medical staff practicing at this Medical Center hereby organize themselves for self governance in conformity with the laws, regulations and policies governing VHA and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing VA, and they do not create any rights or liabilities not otherwise provided for in laws or regulations.

The purpose of the medical staff is to organize the activities of qualified physicians and other clinical practitioners who practice at the Kansas City VA Medical Center in order to carry out the functions delegated to the medical staff by the Governing Body (Medical Director) in conformity with the laws, regulations and policies governing VHA and these bylaws. The members of the medical staff work together as an organized body to promote a uniform standard of quality patient care, treatment, and services and to offer advice, recommendations, and input to the Governing Body.

Responsibilities of the organized medical staff include the following:

1. To develop, amend, and adopt bylaws, policies, and procedures to determine its governance and administrative structures and the processes for carrying out its work, subject to the ultimate authority the Governing Body.
2. To establish standards of patient care and ensure that every patient admitted to or treated by any provider of this Medical Center shall receive the best possible care our resources can furnish. Quality of health care, treatment and services will be ensured through continuous monitoring and evaluating of care, identifying and resolving problems, identifying and acting on opportunities to improve patient care.
3. To establish criteria for membership, credentialing, and privileging of all licensed independent practitioners authorized to practice in this Medical Center.
4. To ensure a high level of professional performance through establishment and maintenance of an effective mechanism to monitor (performance measurement system), evaluate and improve the quality of patient care and the clinical performance of individuals.
5. To serve in a leadership role in hospital performance improvement activities to improve quality of care, treatment, services and patient safety.
6. To provide an appropriate educational setting which maintains scientific standards, leads to continuous advancement in professional knowledge and skills, and supports education of students and residents.
7. To establish, and assure adherence to, ethical standards of professional practice and conduct.
8. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and Medical Center Management.
9. To provide education and training to healthcare professionals and to perform research that benefits veterans.

ARTICLE 1

ORGANIZATION AND GOVERNANCE OF THE MEDICAL STAFF

SECTION 1: OFFICERS

VHA has no requirement for officers of the Medical Staff.

SECTION 2: CHIEF OF STAFF (COS)

The Chief of Staff functions as the President of the Medical Staff. The Chief of Staff is selected and assigned by the facility Director, VISN Director and VHA Headquarters. Should the Chief of Staff be removed from their position, he/she would no longer serve as the President of the Medical Staff. Procedures for actions against Title 38 employees (including Chiefs of Staff) is contained in VA Manual MP-5, Part II, Chapter 8. The Service Chiefs and the Executive Committee of the Medical Staff (ECMS) assist the Chief of Staff.

The Chief of Staff (President of the Medical Staff) is the medical staff's advocate and representative in relationship with the Governing Body and the administration. He or she usually serves as the chair of the Executive Committee of the Medical Staff (ECMS) and ex-officio member of all other medical staff committees, participating as invited on hospital committees. The COS must enforce the medical staff bylaws and continually evaluate and report to the governing body, ECMS, and administration on the effectiveness of the credentialing and privileging processes. It is also customary for the COS to appoint committee chairpersons and members.

Job eligibility requirements for the COS include, but are not limited to, the following:

- Is an active staff member in good standing with no adverse recommendations concerning medical staff appointments/privileges, no sanctions, and no professional conduct or quality issues
- Has previously served in a significant medical staff leadership position or equivalent (e.g., service as a department or committee chair or as a member of the executive committee)
- Has received training in medical staff leadership, or demonstrates a willingness to attend such training during the term of office
- Has demonstrated an ability to work well with others and in compliance with the professional conduct policies of the medical center
- Fully discloses all conflicts of interest or interest in competing healthcare entities
- Demonstrates the ability to work positively and communicates well with colleagues, hospital; administration, and the governing body.
- Recognizes and agrees to the commitment of time needed to perform medical staff duties, and assumes responsibility for participation in continuing leadership education

ARTICLE 2

MEDICAL STAFF MEMBERSHIP

SECTION 1: NATURE OF MEDICAL STAFF MEMBERSHIP

A. Membership of the Medical Staff of the Kansas City VA Medical Center is a privilege, which shall be extended only to professionally competent physicians, optometrists, podiatrists, dentists, doctors of chiropractic, Ph.D./Psy.D. Psychologists, Ph.D. audiologists, and Ph.D. speech pathologists, who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and by the Department of Veterans Affairs' rules, regulations, and policies.

B. Membership on the staff of this Medical Center will include the following categories: Full-time, temporary full-time, part-time, and intermittent staff physicians, dentists, optometrists, podiatrists, doctors of chiropractic, Ph.D./Psy.D. Psychologists, Ph.D. audiologists, and Ph.D. speech pathologists. All members of the Medical Staff are considered to have active membership. VA employees, consultants, Without Compensation (WOC) appointees and contractors may receive appointments to the medical staff.

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

SECTION 2: QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

It is the policy of the Kansas City VA Medical Center to grant and maintain medical staff membership and clinical privileges only to those practitioners who continuously meet the following criteria:

1. Possess appropriate education degrees (Doctor of Medicine, Osteopathy, Dentistry, Optometry, Podiatry, Chiropractic, or a Ph.D. in Psychology [Ph.D. or Psy.D.], Audiology or Speech Pathology from an approved college or university) and demonstrate the relevant training and/or experience, current competence, knowledge, judgment, ability to perform, and technique in his or her specialty for all privileges requested. Exceptions require approval from the Chief of Staff, Director, and possibly VA Headquarters.
2. Possess active, current, full, and unrestricted license to practice in one of the States, Territories or Commonwealth of the United States or the District of Columbia. Those not licensed to practice in any State, Territories or Commonwealth of the United States or the District of Columbia may be appointed members under the provisions of 38 USC 4114 (d). The Undersecretary for Health or his/her designee may waive the licensure requirements of a physician or dentist if he/she is to be solely involved in research or academic activities or in other positions where there is no direct responsibility for patient care.
3. Maintain appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards by consistently acting in a professional, appropriate, and collegial manner with others in clinical and professional settings.
4. Demonstrate proficiency in the use of the computer and VA computer systems to support patient care.
5. Upon request, provide evidence of both physical and mental health that does not impair the fulfillment of his or her responsibilities of his or her medical staff membership and the specific privileges requested by and granted to the practitioner.
6. Possess appropriate written and verbal communication skills and demonstrate proficiency of the English Language.
7. Evidence of current professional liability insurance as required by Federal and VA acquisition regulations.

SECTION 3: BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

- A. Provide for continuous high quality care of patients and arrange transfer of care when appropriate.
- B. Participate in performance improvement, patient safety, peer review, and medical staff monitoring and evaluation.
- C. Maintain standard of ethics and ethical relationships that include:
 - 1. Abide by the Medical Staff Bylaws, Rules and Regulations and all other lawful standards, policies and rules of the Kansas City VA Medical Center, VISN 15, and VHA. Comply with facility, VISN 15 and VHA policies regarding ethical practice of medicine and ethical conduct to include professional courtesy and functioning in a manner to educate and support other employees. Abide by federal law and VA rules and regulations regarding outside professional activities for remuneration (MP-5, Part II, Ch 13 and its supplements, Ethics Reform Act). Medical staff members are especially admonished to refrain from activities, which might have the appearance of a conflict of interest. Additionally, full time staff members must not engage in any outside activity, which would limit their availability to care for VA patients. Title 5 employees will follow the guidelines as outlined in the FPM Manual, Chapters 531 and 610. All members of the Medical Staff are expected to comply with VHA Handbook 5011, Official Time and Attendance.
 - 2. Practicing within the scope of privileges granted by the Medical Center Director and advise the Medical Center Director/Chief of Staff of any change in his/her ability to meet fully the criteria for Medical Staff membership or to carry out clinical privileges that are held. On-call requirements include the ability to be contacted readily and respond in a matter of minutes. When on-call, the practitioner must be within a 30 -60 minute drive of the Medical Center or as clinically appropriate.
 - 3. Advise the Medical Center Director/Chief of Staff of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of notification of such occurrences and their outcomes.
 - 4. Ethical practices as outlined by the national bodies such as, the American Medical Association, the American Dental Association, the American Osteopathic Association, the American Podiatry Association, the American Chiropractic Association, the American Psychological Association, the American Optometric Association, the American Society for Microbiology, and the American Speech, Language and Hearing Association, whichever is applicable, will be strictly followed. Members of the Medical Staff may opt to not participate in procedures to which they object on an ethical, cultural or religious basis, without fear of reprisal or other action, providing care of the patient is properly transferred and documented. Additional information can be found in the related hospital policy memoranda.
- D. Actively participate in student and resident education, as required, and comply with GMEC/RRC/ACGME requirements as required.
- E. Participate on hospital committees, task forces, boards, attend meetings, etc. as requested.
- F. Maintain licensure requirements, CME, and other privileging requirements (e.g. ACLS, etc.)

ARTICLE 3

APPOINTMENT AND INITIAL CREDENTIALING (PER VACO POLICY)

SECTION 1: PROCEDURES FOR APPOINTMENT

A. Authority

1. All members of the Medical Staff shall be appointed under the provisions of Title 38 United States Code, (VA manual DM&S Supplement MP-5, Part II, Chapter 2), or Title 5 (DM&S Supplement MP-5, Part I, Chapter 338). Procedures for appointment of Doctor of Chiropractic Medicine are published in VA Handbook 5005, Part II, Appendix H10.

2. Scarce medical specialty contracts are executed under the provisions of federal and VA acquisition requirements. (VAR, FAAR) Medical Staff members performing under these contracts will meet requirements for appointment as stated in this Article (VHA Handbook 1100.19)

B. Regularly appointed United States citizen staff members shall be granted an initial two-year probationary appointment with career appointment to follow subject to annual review.

C. For licensed non-citizen individuals with permanent (immigrant) visas, appointments will be three years, temporary renewable and subject to annual review (DM&S Supplement, MP-5, Part II, Chapter 2, paragraph 2.O8).

D. Application information.

1. **Burden of Proof.** The applicant has the burden of obtaining and producing all necessary, adequate, verifiable, and complete information for a proper evaluation of his/her 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 his/her qualifications. If information provided by the applicant varies substantially from information obtained through the VA credentials verification process, the applicant will be notified by the Credential Office staff, in collaboration with the Chief of Staff. The applicant has the right to provide written information that he/she believes will correct any discrepancy or error. Failure to provide necessary information within 30 days may serve as a basis for denial of employment consideration.

2. **Complete Application.** To complete applications for appointment they must be submitted by the applicant on forms approved by the VA and/or the Medical Center (VHS&RA Supplement, MP-5, Part II, Ch.1, para.2.44 a.), submitted through Vet Pro, and include information regarding:

(a) Items specified in Article III, Section 2, Qualifications for Medical Staff Membership:

Active, current, full and unrestricted License
Education
Relevant Training and/or Experience
Current competence
Physical and Mental Health Status
Residence Geographic Location
Professional Liability Insurance (contractors)
English Language Proficiency
Absence from OIG Sanction List

(b) **U.S. Citizenship.** Must be a citizen of the United States. Practitioners who are not citizens will be eligible for consideration for appointment, with proof of VISA status, when it is not possible to recruit qualified citizens, pursuant to qualifications as outlined in VA regulations (MP-5, Part II, ch. 2 and its VHS&RA Supplement) and provided by 38 U.S.C. 4114 or Title 5.

(c) **References.** Names and addresses of three (3) individuals who are qualified as peers or supervisors to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as medical staff member within privileges requested;

(d) **Previous Employment.** List of all health care institutions where the practitioner is/has been appointed or employed, including:

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

(e) **DEA Registration:**

For those who have DEA certificates, (list any)
previously successful or currently pending challenges to DEA registration or the voluntary relinquishment of such registration..

(f) Challenges to License including whether a license or registration ever held to practice a health occupation by the practitioner has been suspended, revoked, voluntarily surrendered or not renewed.

(g) Status of any claims made against the practitioner in the practice of any health occupation and the status of the claim.

(h) Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

(i) Pending challenges against the practitioner by any hospital, licensing board, law enforcement agency, professional group or society.

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

3. Documents required in addition to those listed above include:

(a) Pre-employment References from the current or most recent employer and two other references who can provide authoritative information regarding training/experience, professional competence and conduct and health status.

(b) Documentation of Current or Most Recent Clinical Privileges held, if available.

(c) Verification of Licenses for all States in which the applicant has ever held a license.

(d) Educational Commission for Foreign Medical Graduates (ECFMG) verification, for foreign medical graduates.

(e) Evidence and verification of Board Certification, if claimed.

(f) Verification of Education Credentials used to qualify for appointment (and privileges).

(g) Reports of queries from National Practitioner Data Bank (NPDB) and OIG Sanction list for all practitioners.

(h) Review of Bylaws, Rules, Regulations, and policies with signature certifying their review and compliance.

SECTION 2: PROCESS AND TERMS OF APPOINTMENT

- A. **The Service Chief** of the program to which the applicant is to be assigned is responsible for recommending appointment, based upon background checks, interviews, and pre-employment recommendations and evaluation of the applicant's credentials and determination that the program's criteria for clinical privileges are met.
- B. **The Executive Committee of the Medical Staff - Professional Standards Session**, will examine all application materials before making a recommendation regarding appointments to the Medical Center Director. Included in this are pending or settled malpractice claims; prior work records; challenges to and/or voluntary relinquishment of any licensure or registration; voluntary or involuntary termination of medical staff membership; limited, revoked or suspended privileges (voluntary or involuntary) at other institutions; and qualifications for clinical privileges that meet the needs of this Medical Center.
- C. **Appointments** shall be approved by the Medical Center Director within three (3) weeks of receipt of a fully complete application including recommendations from the appropriate service chief, Professional Standards Board (PSB), and when applicable, the Chairman of the department at the university (ies) in which the individual holds an academic appointment.
- D. **Candidates for appointment** who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment. In the case that appointment is not approved, reasons will be provided.
- E. **Probationary Period.** Initial appointments made under authority of Title 38 USC 4104 are probationary. During this time the appointee's professional competence, performance and professional conduct will be evaluated by the appropriate Service Chief, and reviewed by the Chief of Staff, and the appropriate. Professional Standards Board (PSB). At the end of two years, if the applicant has demonstrated an acceptable level of performance and conduct, probationary status will be lifted. Individuals, appointed under Title 5, must serve a one-year probationary period during the first year of Title 5 appointment. Supervisors and managers will apply similar processes to the evaluation of individuals employed under provisions of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.
- F. **Temporary Appointment.** When there is an emergent or urgent patient care need, a temporary appointment may be made by the Kansas City VA Medical Center Director. Prior to receipt of references or verification of other information and action by the ECMS, evidence of current licensure verification, conformation of possession of comparable clinical privileges and a reference will be made prior to making such an appointment. National Physicians Data Bank (NPDB) query will also be initiated at the time of the temporary appointment.
- G. **Salary Determination.** Determination of salary will be in accordance with Department of Veterans Affairs Handbook 5007. Pay is based upon longevity in the VA, and market pay. Performance pay will also be available based on yearly goal achievements. Recruitment and retention incentives are also available.

ARTICLE 4

CLINICAL PRIVILEGES

SECTION 1: DELINEATION OF CLINICAL PRIVILEGES

A. Medical Center specific privileges are granted for a period not to exceed two years and considered for renewal every two years.

B. Granting, renewing, or revising setting-specific clinical privileges will be handled in accordance with policies outlined in this document. Any physician or non-physician health care provider who is permitted to initiate, alter or terminate a treatment regimen must have appropriate clinical privileges/scope of practice statement. Credentials that are subject to change during leaves of absence will be subject to review at the time the individual returns to duty.

C. Service Chiefs will establish written criteria for recommending clinical privileges for their staff members and will certify annually that the criteria have been reviewed and modified as necessary. The Service Chief will be responsible for the recommendation for granting, renewing, limiting, expanding, denying, or withdrawing clinical privileges (to include setting specific) and will be responsible for the annual performance evaluation or proficiency rating of each professional staff member. If the Service Chief is not a physician he/she must defer evaluation of clinical competency of clinical staff to the Clinical Leader, Section Chief or Chief of Staff. The clinical competence component as outlined in the Proficiency Report includes categories 1, 2, and 3 (clinical competence, educational competence, and research and development) as well as overall rating. The Physician Performance Appraisal at KCVAMC has been standardized and includes the definitions and criteria.

D. Every initial application for appointment must be accompanied by a separate request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, peer recommendations, and other relevant information, including an appraisal by the clinical discipline and program in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges he/she requests.

Initial clinical privileges for new employees will be provisional for a period of six months and a period of focused professional practice evaluation will be implemented. During this period a proctor assigned by the Service Chief must directly observe the performance and clinical competence of the practitioner, at least periodically and that individual must submit a formal written evaluation of the practitioner's performance to the Service Chief and Chief of Staff. The appropriate professional standards board will consider the evaluation and recommend action.

E. Granting of clinical privileges will be based on clinical criteria, will be governed by applicable VA regulations, the scope of their licenses, applicable statutes and consistent with the Medical Staff's regulations. At the time of application for clinical privileges, they shall agree to comply with all applicable Medical Staff Bylaws, Rules and Regulations. House Officers will function within the clinical privileges as determined by the attending staff responsible for the resident. Applications from residents for privileges are not required except when functioning outside of their training capacity (such as AOD's, chief residents and fellows functioning as attendings).

F. Privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists in the operating rooms of the Surgery Service, shall be under the overall supervision of the Chief of Surgery.

G. Qualified, licensed physicians, dentists, podiatrists, optometrists, and chiropractors are granted Medical Center privileges by the Medical Center Director, based on the recommendation of the ECMS - Professional Standards Board.

H. Temporary Privileges in Emergency Situations Licensed physicians and dentists with expertise not available to the Medical Center by existing staff appointments can be authorized privileges by the facility Director on a temporary basis. Temporary privileges in emergency situations may be granted at the time of a temporary appointment. Such privileges will be based on documentation of a current state license, other reasonable, reliable information concerning training and current competence. The recommendation for temporary privileges will be made by the Service Chief to the Chief of Staff and approved by the facility Director. Temporary privileges

should not exceed 60 days. Termination of a practitioner's temporary privileges is not subject to appeal. The facility Director may at any time, on recommendation of the Chief of Staff, terminate a practitioner's temporary privileges. Such action is not subject to appeal.

I. In case of emergency, any physician, dentist or osteopathic physician member of the organized Medical Staff, to the degree permitted by his/her licenses and regardless of program or staff status, shall be permitted and assisted in doing everything possible to save the life of a patient.

J. Other licensed individuals (allied health professionals) who are presently permitted by law to provide patient care services independently, may be granted clinical privileges based on their assignments and responsibilities. When this is done, the responsibilities of physicians/dentists in relation to these professionals must be specified.

K. Requirements for requesting and granting privileges are the same for all practitioners who hold privileges.

L. Individuals with clinical privileges are assigned to and have clinical privileges in one clinical discipline/program, but may be granted clinical privileges in other clinical disciplines/programs.

M. Service Chiefs will establish and maintain a mechanism to assure that all individuals with clinical privileges function within the scope of privileges granted. A written procedure outlining this mechanism will be approved by the ECMS PSB and the facility Director. Copies of clinical privileges will be available to hospital staff on a need to know basis in order to assure providers are operating within the scope of their clinical privileges.

N. When granting of clinical privileges is contingent on appointment to the faculty of the medical or other health professional school affiliate, loss of faculty status will result in termination of existing clinical privileges.

O. Additional specific information is available in Medical Center Policy Memorandum 11-44, "Appointment, Privileging and Reprivileging, Promotion."

P. Focused review of Practitioner's Performance: A "peer" is defined as an individual practicing in the same profession. The level of subject matter expertise required to provide a meaningful evaluation of care will determine what "practicing in the same profession" means on a case-by-case basis. For all peer review or focused reviews performed by the medical staff, the COS will determine the degree of subject matter expertise required for a provider to be considered a peer. (Focused review is an intensive review to determine whether a practitioner's performance may require further action to improve that practitioner's performance). The method for selection of a focused review panel or "peer" will be the decision of the Chief of Staff, and based upon the situation requiring review, the expertise required and the need to assure objectivity and confidentiality. The focused review will be conducted in a timely manner with the goal to complete this review within 45 days of identification of need. Participation in this review process by the provider whose performance is being reviewed would be accomplished by requesting his/her input regarding the issue or performance under review. Feedback and request for response would be, at a minimum, solicited upon PRB's review of findings of the focused review. Determination of action would incorporate the feedback from the provider.

Focused review will be conducted when an unusual clinical pattern of care or other major adverse issues are identified or abnormal trends in quality of care/performance improvement data. Circumstances requiring external peer review will be utilized for case(s) of: litigation, ambiguity, lack of internal expertise, new technology, and/or other miscellaneous issue such as benchmarking, expert witness for a fair hearing, evaluation of a credentialing file. The ECMS is involved in: (1) evaluation of individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities; (2) communication to the appropriate parties of the findings, conclusions, recommendations, and actions taken to improve practitioner performance; and (3) implementation of changes to improve performance. Timeframes in which peer reviews activities are to be conducted and the results reported is so noted in the Hospital's Performance Improvement Plan.

SECTION 2: PROCESS AND REQUIREMENTS FOR REQUESTING CLINICAL PRIVILEGES

A. Burden of Proof. The individual requesting clinical privileges, initial or renewal, has the burden of obtaining and producing all necessary, adequate, verifiable, and complete information for a proper evaluation of his/her professional competence, professional conduct, ethics and other qualifications requested and for resolving any doubts concerning such qualifications. Failure to provide necessary information in a timely manner of 60 days may

serve as a basis for denying initial privileges or renewal of privileges.

B. Practitioner Requests for Clinical Privileges, initial and renewal, must be made in writing and include privileges requested within well-defined limits utilizing the format approved by the Medical Staff. Practitioners may submit a request for modification of clinical privileges at any time. The facility queries the NPDB at the time of initial medical staff appointments to membership and initial granting of clinical privileges, and at the time of expanding privileges or requesting to add new privileges as well as at least every two years thereafter for information on physicians, dentists, and other health care practitioners granted clinical privileges. Requests will be accompanied by the appropriate documentation, which supports the practitioner's assertion of competence. An explanatory statement should accompany requests for changes, which should be submitted through the service chief.

C. The practitioner applying for initial clinical privileges must submit a complete application for privileges, which will include:

1. Complete appointment information as outlined in Article IV.
2. Application for clinical privileges as outlined in this Article.
3. Curriculum Vitae

D. The practitioner applying for renewal of clinical privileges will provide the following information for use in reappraisal of credentials, professional performance and competence and renewal of clinical privileges:

1. Application for clinical privileges as outlined in this Article. (Since practice and techniques change over time, it is expected that modifications, additions or deletions to existing clinical privileges will occur.)
2. Supporting documentation of training and/or experience not previously submitted.
3. Physical and mental health status as it relates to his/her ability to function within privileges requested.
4. Documentation of continuing medical education, consistent with area and scope of clinical privileges, (specify any minimum requirements, e.g. consistent with minimum state licensure requirements, etc.) not previously submitted.
5. Status of all licenses, certifications held.
6. Additional information, i.e., names of other hospitals or other health care institutions in which the individual holds medical staff membership and/or clinical privileges held.
7. Any sanction(s) by a hospital, state licensing agency or any other professional health care organization; voluntary or involuntary relinquishment of licensure or registration; any malpractice claims, suits, settlements and/or final judgments; reduction or loss of privileges at any other hospital such disclosure must be made no later than the time of the request for repriviling.

E. Bylaws Receipt and Pledge. Prior to the granting of clinical privileges, initial or renewal, Medical Staff members or applicants will pledge to provide for continuous care of their patients and arrange transfer of care. The applicant will receive a copy of the Bylaws, Rules and Regulations and agree to abide by the professional obligations therein.

F. Verification.

1. Verification of credentials prior to granting of initial privileges will be accomplished as described in this Article.
2. The credentialing process includes a mechanism to ensure that the individual requesting approval is the same individual identified in the credentialing documents. The Credentials Coordinator or Human Resources will personally review and examine a photo ID – driver's license, school ID, or military ID - to verify the individual requesting privileges is in fact the same individual who is identified in the credentialing

documents.

3. For renewal or revision of clinical privileges, Kansas City VA Medical Center C&P office and the responsible Service Chiefs, will assure that the following reappraisal and credentials information is on file and verified with primary sources as appropriate:

- Current licenses in all states
- Current DEA license and/or registration
- National Practitioner Data Bank query
- Physical and mental health status information from applicant, clinical chief, peer
- Continuing education to meet requirements for privileges requested
- VISA and naturalization status
- Board certification(s)
- Quality of care information
- Absence from OIG Sanction List

G. For employees employed under Title 38, at the time of their annual proficiency evaluation, the proficiency form will be initiated by Human Resources, Network Business Office, and routed through the service chief, Patient Care and Performance Improvement (PPCI) for the determination of the requirement for clinical privileges. If clinical privileges are to be renewed, the Application for Renewal of Clinical Privileges, the Quality of Care Appraisal form and Reappraisal Assessment will be completed. When privileges are due for renewal, PPCI will provide the Service Chief with a Quality of Care Appraisal form and the annual performance appraisal form.

H. However, the Service Chief is responsible for ensuring the verification of current licensure, professional performance, technical skills and health status. Additionally, information will be provided regarding adverse actions, previous, successful or current pending challenges to licensure or registration, or the voluntary relinquishment of such licensure or registration, voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, and involvement in liability actions, with final judgments and settlements and other reasonable indicators or continuing qualifications. Peer recommendations are also part of the basis of development of recommendations for continued membership on the medical staff and/or the delineation of individual clinical privileges.

I. The proficiency form, request for renewal of privileges and all other information obtained will be forwarded to the ECMS - Professional Standards Session, for consideration.

SECTION 3: MEDICAL STAFF APPOINTMENTS AND REAPPRAISALS

A. Every Medical Staff member is required to have on file a current license, record of formal medical training and a record of any board certification.

B. Every Medical Staff member's proficiency will be appraised annually in accordance with VHA and KCVAMC regulations. The service chief will request medical staff members to conduct a self-assessment, prior to the completion of the appraisal. The completed appraisal will be sent to the Chief of Staff for review and signature. The Service Chief will then meet with the medical staff member to review and discuss their proficiency. Key components include the categories of direct patient care, administration, education, research, and personal qualities.

C. Practitioners and allied health professionals whose patient care activities require delineation of clinical privileges may render clinical services to Medical Center patients under the following conditions:

1. Each individual in this category will present his/her request for clinical privileges and qualifications for review by the appropriate Service Chief and Professional Standard Board. If approved, the Governing Body may grant such individuals privileges.
2. They may not admit patients nor write orders for patient care except under certain circumstances as outlined under admitting procedures in Rules and Regulations.
3. Services will be performed under the supervision of a member of the Medical Staff who will be responsible for the patient and their records in all respects.

SECTION 4: EXCEPTIONS

A. Temporary clinical privileges for emergent or urgent patient care needs may be granted for a limited period of time (not to exceed 45 workdays) by the Medical Center Director or the Acting Medical Center Director, in the absence of the Director, on the recommendation of the Chief of Staff. Temporary privileges will be based on evidence of a current State license and other reasonably reliable information concerning training and current competence.

B. Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of his/her license, to save a patient's life or save the patient from serious harm. Properly supervised members of the house staff may also provide emergency care.

C. Expedited Medical Staff Appointment Process: To expedite appointment, reappointment, or renewal or modification of clinical privileges, the governing body may delegate the authority to render those decisions to a committee consisting of at least two governing body members. Following a positive recommendation from the Executive Committee of the Medical Staff (ECMS) on an application, the committee of the governing body (Director) reviews and evaluates the qualifications and competence of the practitioner applying for appointment, reappointment, or renewal or modification of clinical privileges and renders its decision. A positive decision by the committee results in the status or privileges requested. The full governing body considers and, if appropriate, ratifies all positive committee decisions at its next regularly scheduled meeting. If the committee's decision is adverse to an applicant, the matter is referred back to the Medical Staff Executive Committee for further evaluation. The committee shall meet as often as necessary as determined by its chairperson.

An applicant is usually ineligible for the expedited process if at the time of appointment, or if since the time of reappointment, any of the following has occurred:

1. The applicant submits an incomplete application;
2. The Medical Staff Executive Committee makes a final recommendation that is adverse or with limitation;
3. There is a current challenge or a previously successful challenge to licensure or registration;
4. The applicant has received an involuntary termination of medical staff membership at another organization;
5. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;
or
6. There has been a final judgment adverse to the applicant in a professional liability action."

The KCVAMC incorporates by reference the following process into the Medical Staff Bylaws, Credentialing and Privileging policy (Policy Memorandum 11-44) procedures for an expedited appointment process for medical staff appointments not to exceed 30 workdays during which time full credentialing must be completed. This process will assist in expediting the medical staff appointment process.

1. Critical to the implementation of the Expedited Appointment is the commitment of the KCVAMC service chiefs to assuring the timely completion and submission of the credentials information package through VetPro, with the necessary local facility supplements. The credentialing process cannot begin until the licensed independent provider completes the credentials package. Joint Commission requires that there be a complete application for an expedited appointment, therefore the provider must submit this information through VetPro and documentation of credentials must also be retained in VetPro.
2. Credentialing requirements for this process includes confirmation of:
 - (a) The practitioner's education and training (which, if necessary, can be accomplished in 24 hours through the purchase of the American Medical Association's Practitioners Profile);
 - (b) One active, current, unrestricted license verified by the primary source State, Territory, or Commonwealth of the United States or in the District of Columbia;

NOTE: To be eligible for appointment to a position listed in Title 38 United States Code (U.S.C.), Section 7402(b), an applicant or employee must meet its statutory licensure requirements for the position. In addition, a person may not be employed in any position under Title 38 U.S.C., Section 7402(b) (other than as a Director of a hospital, domiciliary, center or outpatient clinic), if the person is or has been licensed, registered, or certified in more than one State, and either (1) any of those States has terminated such license, registration or certification for cause, or (2) the person has voluntarily relinquished such license, registration, or certification in any of those States after being notified in writing by that State of potential termination for cause. See Title 38 U.S.C., Section 7402(f).

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

(d) Query of licensure history through the Federation of State Medical Boards Action Data Center;

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

(f) Current comparable privileges held in another institution; and

(g) National Practitioner Data Bank query.

3. If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted, and there is no history of malpractice payment, a delegated subcommittee of the ECMS, consisting of at least two members of the full committee, may recommend appointment to the medical staff. Full credentialing will be completed within 30 workdays and presented to the Executive Committee of the Medical Staff for ratification.

NOTE: The expedited appointment process may only be used for what are considered to be "clean" applications. The expedited appointment process can not be used if the application is not complete (including answers to Supplemental Questions, Declaration of Health, and Bylaws Attestation); there are any current or previously successful challenges to licensure; ANY history of involuntary termination of medical staff membership at another organization, received involuntary limitation, reduction, denial, or loss of clinical privileges; or there has been a final judgment adverse to the applicant in a professional liability action.

4. This recommendation by the delegated subcommittee of the Executive Committee of the Medical Staff will be acted upon by the VHA medical treatment facility Director. The 30 workdays for the completion of the full credentialing process begins with the date of the Director's signature.

5. This process does not relieve the local VHA medical treatment facilities from reviewing the Department of Health and Human Services, Office of Inspector General's sanction list and determining that the provider has not been excluded from receiving or directing the expenditure of Federal health care dollars.

6. The expedited appointment to the medical staff process does not relieve VHA medical treatment facilities from any human resources appointment requirements. See VA Handbook 5005, Staffing.

7. For those providers where there is evidence of a current or previously success challenge to any credential or any current or previous administrative or judicial action, the expedited process cannot be used and complete credentialing must be accomplished for consideration by the Executive Committee of the Medical Staff.

8. This is a one-time appointment process for initial appointment to the medical staff and may not exceed 30 workdays. It may not be extended or renewed. The complete appointment process must be

completed within 30 workdays of the Expedited Appointment or the medical staff appointment will automatically be terminated.

D. Granting privileges in the event of a disaster: During a disaster(s) in which the Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs, the Medical Center Director or his or her designee(s) has the option to grant disaster privileges. Privileges may be granted to volunteers eligible to be Licensed Independent Practitioners. The option to grant disaster privileges to volunteer practitioners is made on a case-by-case basis in accordance with the needs of our organization and its patients, and on the qualification of its volunteer practitioners. The responsibilities of the individual accountable for granting disaster privileges is that any of the following will be obtained prior to granting disaster privileges:

1. A current picture hospital ID card that clearly identifies professional designation.
2. A current license to practice.
3. Primary source verification of the license. (Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization). In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication, or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required timeframe; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal or state or federal organizations or groups.
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances; (such authority having been granted by a federal, state, or municipal entity).
6. Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

Upon approval, the practitioner shall be issued appropriate Medical Center security identification as may be required by the Medical Center, and shall be assigned to a Medical Staff member, in the same specialty if possible, with whom to collaborate in the care of disaster victims. The Service Chief will designate a medical staff member to oversee the professional practice of volunteer licensed independent practitioners who receive disaster privileges.

The medical center director makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

SECTION 5: CREDENTIALS EVALUATION AND MAINTENANCE

A. Determination will be made that the individual applying for clinical privileges, initial or renewal, has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested through evaluation of all credentials, peer recommendations, available quality of care information including medical staff monitors.

B. A good faith effort will be made to verify, with primary sources, all credentials claimed, whenever feasible. A "good faith effort" to verify is defined as at least two (2) attempts at verification.

C. A Credentialing and Privileging Folder will be established and maintained for each practitioner requesting privileges. These folders will be the responsibility of the Service Chief, PPCI and PPCI will maintain a copy of all documents relevant to credentialing and privileging.

SECTION 6: RECOMMENDATIONS AND APPROVAL

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

B. The Service Chief to whose section the applicant for clinical privileges is assigned is responsible for assessing all information and recommending approval of clinical privileges, initial or renewal.

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

2. Recommendation for renewal or revision of clinical privileges will be based on reappraisal of physical and mental health status, peer recommendations (from peers in the same professional discipline as the applicant), continuing education, professional performance (to include that the practitioner does not practice outside the scope of their privileges), judgment and clinical and/or technical skills and quality of care including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, pharmacy and therapeutics review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities). Relevant practitioner-specific data are compared to aggregate data if such data are available for that practitioner and also, morbidity and mortality data, if such data are available for that practitioner.

C. The ECMS - Professional Standards Session recommends granting of clinical privileges based on an applicant successfully meeting the requirement for clinical privileges as specified in these Bylaws.

D. Clinical privileges, initial and renewal, are approved by the Medical Center Director within three weeks of the time an application for clinical privileges is made complete as described in this Article.

ARTICLE 5

FAIR HEARING AND APPELLATE REVIEW

SECTION 1: DENIAL OF MEDICAL STAFF APPOINTMENT

When review of credentials and recommendations contained in a complete application result in denial of appointment, the appropriate approving authority will notify the applicant that appointment has not been recommended and briefly state the basis for the action.

SECTION 2: ACTIONS AGAINST CLINICAL PRIVILEGES

A. There are mechanisms including fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, revocation of privilege that may relate to quality of care, treatment and service issues. An appeal process as outlined in VHA Handbook 1100.19 (Handbook 1100.19 Credentialing and Privileging) will be available and explained to the employee.

B. When recommendations regarding clinical privileges are adverse to the applicant, procedures specified in VHA Handbook 1100.19 will be followed.

C. Disciplinary and performance based privilege changes are undertaken after due process procedures as outlined in VHA Handbook 1100.19 are exhausted.

D. The Kansas City VA Medical Center Director may summarily suspend privileges on a temporary basis, as outlined in VHA Handbook 1100.19.

E. Other privileged employees (e.g. speech pathologists) not covered by VHA Handbook 1100.19 may appeal privilege decisions in accordance with Chapter 8.

F. Disciplinary actions, grievances, appeals and hearings will be conducted in accordance with DVA Handbook 5021, Part II.

G. When administrative procedures, associated with processes described in the bylaws for corrective actions, fair hearing and appeal, credentialing, privileging, and appointment are described in medical staff governance documents that supplement the bylaws(i.e. rules and regulations, and policies) the following must occur: mechanism for approval of the administrative procedures, which may be different from that for adoption and amendment of the medical staff bylaws, is described in the medical staff bylaws. Criteria to identify those administrative procedures that can be in the supplementary documents are described in the bylaws. The administrative procedures are approved by both the medical staff and the governing body through the bylaws-described mechanism.

SECTION 3: REPORTING ADVERSE ACTIONS

A. Disclosure of information to State licensing boards regarding practitioners separated from VA service, when a practitioner so significantly fails to conform to generally accepted standards of clinical professional practice as to raise concern for the safety of patients, will follow provisions in the current VHA Handbook 1100.18. Handbook 1100.18. Reporting and Responding to State Licensing Boards

B. Disclosure of information to the National Practitioner Data Bank through State licensing boards regarding adverse action against clinical privileges of more than 30 days will follow provisions of the current VHA Handbook 1100.19 and VHA Handbook 1100.17. Handbook 1100.17 National Practitioner Data Bank Reports

SECTION 4: REPORTING MALPRACTICE PAYMENTS

Disclosure of information regarding malpractice payments determined to be made for the benefit of a practitioner will follow provisions of Handbook 1100.17 National Practitioner Data Bank Reports

SECTION 5: TERMINATION OF APPOINTMENT

Procedures to be followed in terminating appointment of practitioners are set forth DVA Handbook 5021 Part II. Due process will be adhered to pursuant to procedures contained in this Handbook.

ARTICLE 6

IMMUNITY FROM LIABILITY

FEDERAL TORT CLAIMS ACT

A. The Federal Tort Claims Act provides for civil actions against the United States for money damages "...for injury or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee of the government while acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred" (28 U.S.C. 1346(b)). Excepted from the application of the Act are claims arising out of certain intentional torts such as assault, battery, false imprisonment, libel, slander, and misrepresentation (28 U.S.C. 2680).

B. While the Federal Tort Claims Act provides a remedy against the government, a type of statutory immunity from malpractice liability exists with respect to medical personnel of the Department of Medicine and Surgery; a person claiming "damages for personal injury, including death, allegedly arising from the malpractice or negligence of a physician, dentist, podiatrist, chiropractor, optometrist, nurse, physician assistant, expanded function dental auxiliaries, pharmacist, or paramedical (for example, medical and dental technicians, nursing assistants, and therapists) or other supporting personnel in furnishing medical care or treatment while in the exercise of such person's duties in or for the Department of Medicine and Surgery" has only a possible remedy against the Government and not against the employee (38 U.S.C. 4116(a)). Residents, interns and "without compensation employees," (e.g., medical students), may be included provided they are working under the supervision and direction of VA personnel.

C. In a situation in which the immunity statute would not apply, such as a physician being sued for battery on a patient (one of the exceptions under the Federal Tort Claims Act) with a judgment being obtained against the physician, the immunity statute provides that the Secretary of Veterans Affairs may pay the judgment.

D. Each member of the Medical Staff has the responsibility to inform the Chief of Staff of any legal actions brought against him/her for services performed outside of this Medical Center.

E. The Tort Claim process at the KCVAMC is depicted in the flow chart, Appendix 1.

ARTICLE 7

PROFESSIONAL SERVICES

SECTION 1: PROFESSIONAL SERVICES *

Clinical Programs:

Specialty Medicine

Surgery

Primary Care

Radiology

Pathology and Laboratory Medicine

Mental Health

Rehabilitation Medicine and Chiropractic Care

*The Scope of Services provided is delineated in the Programs' PI Plan and Plan for Patient Care.

SECTION 2: CLINICAL SERVICES

The Clinical Services are under the direction of the Chief of Staff. The Service Chief is responsible for the administrative supervision of their respective clinical service as well as formulating and supervising professional activities in this area in collaboration with the chiefs of the involved disciplines. Appropriately privileged Medical Staff members provide emergency services, at all times.

SECTION 3: ORGANIZATION OF SERVICES

- A. The Director will be responsible for the proper and efficient management of the Medical Center.
- B. The Chief of Staff acts as a full assistant to the Medical Center Director in the direction and coordination of the patient care, research, and educational activities of the Medical Center.
- C. Service Chiefs shall be responsible to the Chief of Staff for the functioning of his/her service. Service Chiefs are appointed by the Medical Center Director upon recommendation from the Chief of Staff. Service Chiefs are certified by an appropriate specialty board, or otherwise affirmatively establish comparable competence, through the credentialing process.
- D. The staff of each Service is expected to meet on a regular basis, preferably monthly, to insure adequate communication. Such meetings shall not release the members from their obligation to attend the general Medical Staff meeting(s).

SECTION 4: DUTIES AND RESPONSIBILITIES OF CLINICAL SERVICE CHIEFS:

Each Service Chief shall be accountable to the Chief of Staff and shall be responsible for:

- A. Oversight and management of all clinically related activities of the department or service.
- B. Oversight and management of administratively related activities the department.
- C. Defining qualifications, competence and numbers of staff needed to provide care, treatment, and

services.

- D. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
- E. Recommending clinical privileges for each member of the department.
- F. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
- G. The determination of the qualifications and competence of department or service personnel who are not LIPs and who provide patient care, treatment, and services.
- H. Transmission to the Chief of Staff the program's/discipline's recommendations concerning staff personnel actions and other data relevant to the overall operation of the program/service and the Medical Center.
- I. The development and implementation of programs for orientation of new members/employees and continuing education of all persons in the service. This includes proctoring of new medical staff members in their assigned area.
- J. The integration of the department or services into the primary functions of the organization.
- K. Coordination and integration of inter-departmental and intra-departmental services.
- L. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services and the enforcement of the Medical Center Bylaws and other rules and regulations established by the VA. This would include on-call expectations and timekeeping.
- M. Assessing and recommending non-VA sources for needed patient care, treatment and services not provided by the service or the facility. In addition, referral of patient for off-site services is to be handled in accordance with facility policy (refer to PM 11-110: Request for Non-KCVAMC Care).
- N. The development and implementation of a Performance Improvement Plan and indicators that support the overall Performance Improvement Plan of the KC VAMC.
- O. The continuous assessment and improvement of the quality of care, patient safety, treatment, and services and the maintenance of a quality control programs as appropriate.
- P. Ensuring compliance with requirements of all external and internal accreditation and review bodies.
- Q. Develop monitoring systems and enforcing all provisions of Policy Memorandum 11-24 titled "Supervision of Post-Graduate Medical, Surgical, Dental, Optometry and Podiatric Residents" to ensure all health care trainees under the jurisdiction of the members of the Medical Staff are appropriately supervised.
- R. Implementing recommendations, upon the direction of the Chief of Staff, that of ECMS and other policies and procedures of the Medical Center, VISN 15, and/or VHA.
- S. Ensure service participation in facility-wide resources assignments such as Space Committee, Equipment Committee, etc.
- T. Performing other duties commensurate with his/her office as assigned by the Chief of Staff and/or Director.

ARTICLE 8

COMMITTEES

SECTION 1: APPOINTMENT

The Chief of Staff shall appoint all medical staff committee members including the chair in accordance with VA regulations.

SECTION 2: GENERAL OBLIGATIONS

A. Committees prepare and maintain records of discussion, conclusions, recommendations, action taken and results of actions taken and forward those minutes within a timely manner through channels established by the Medical Staff, i.e. to the Medical Center Director and the Chief of Staff and PPCI.

B. Committee members are expected to attend 60% of ECMS, PRB, & PRC committee meetings unless excused. For all other committees, a quorum is considered 50% or one over half unless otherwise specified in committee policies.

SECTION 3: COMMITTEES AND BOARDS

The following list represents the major standing committees of the Medical Staff. The duties, responsibilities, membership, reporting relationships and requirements of each committee can be found in the associated medical center policy memoranda. Committee minutes must be reported to the Governing Body (Medical Center Director) through the Executive Committee of the Medical Staff.

A. **Executive Committee of the Medical Staff (ECMS)**

1. The ECMS is charged with overseeing the quality of care, treatment and services delivered by practitioners who are credentialed and privileged by the medical staff process. The organized, self-governing medical staff creates and maintains a set of by-laws that defines its role within the context of a hospital setting and clearly delineates its responsibilities in oversight and care of treatment and services. The medical staff has a leadership role in hospital performance improvement activities to improve quality of care, treatment, services and patient safety and participates in the measurement, assessment and improvement of these and other processes. They provide oversight in the process of analyzing and improving patient satisfaction. The medical staff provides for a uniform quality of patient care, treatment, and services. Designated members of the medical staff who have independent privileges provide oversight of care, treatment, and services provided by practitioners with privileges. The ECMS serves as an advisory board and reports directly to and is accountable to the Medical Center Director (Governing Body).

Routine functions of ECMS include:

- (a) Acting on behalf of the medical staff, between regular meetings of the medical staff.
- (b) Oversight of compliance with Joint Commission and other third party accrediting body requirements.
- (c) Responsibility for Performance Improvement and Patient Safety activities.
- (d) Receiving, reviewing, and acting on reports from medical staff committees, medical center committees, programs, and other assigned activity groups.
- (e) Oversight of functional reviews of clinical services and other such reports as required.

(f) Reviewing and modifying as necessary, the Medical Staff Bylaws and associated rules and regulations, at least annually.

(g) Oversight of medical student and resident education (through GMEC).

2. The ECMS meets at least once a month and includes a regular session and a Professional Standards Board session. The session is preceded by the Professional Standards Board (PSB) meeting. The clinical service chief members of ECMS serve as the Professional Standards Board members. This group makes recommendations to the Medical Center Director on appointments, promotions and clinical privileges. ECMS Regular and PSB are chaired by the Chief of Staff.

3. Membership: The increment of service for ECMS members begins January 1 and ends December 31 each year. At a minimum, 80% of the voting membership of the ECMS must be members of the medical staff. All members of the medical staff, of any discipline or specialty, are eligible for membership on the committee. Fully licensed physicians, actively practicing in the hospital, comprise the majority of voting members of the ECMS.

4. Meeting minutes will be kept for each session. Recommendations will be forwarded to the Governing Body (Director) for review and approval.

B. **Medical Records Committee**

C. **Pharmacy and Therapeutics Committee**

D. **Transfusion Committee**

E. **Surgical Case Review Committee**

F. **Operative and Invasive Procedure Review Committee**

G. **Infection Control Committee**

H. **Intensive Care Committee** (Need SICU incorporated)

I. **Cancer Committee**

J. **Graduate Medical Education**

K. **Physician Peer Review Boards**

1. Multidisciplinary Peer Review Committee (PRC): The PRC is multidisciplinary and consists of senior members of key clinical disciplines, chaired by the Chief of Staff. This Committee has responsibility for conducting and documenting peer review for quality management of care provided by an individual provider and reviewing system issues that impact clinical care. Details of this can be referenced in Policy Memorandum 00-81.

2. Physician Peer Review Board (PRB): The PRB consists of members of the medical staff and is chaired by the Chief of Staff. This Committee has responsibility for conducting and documenting peer review for quality management of care provided by an individual provider and reviewing system issues that impact clinical care. Details of this can be referenced in Policy Memorandum 00-81. It conducts peer reviews for performance improvement of care provided by physician members of the medical staff.

SECTION 4: DIRECTOR'S ADVISORY BOARD

Director's Advisory Board (DAB): The DAB consists of the senior management officials, including Service Chiefs, Director, Associate Director, Chief of Staff, Associate Director for Patient Care Services, AA/COS, Staff Asst/Director, and AFGE Presidents. The DAB advises the Director on all aspects of medical center management, establishes policy, promotes performance improvement and provides a forum for organizational management and planning. The Quality Board is a sub-group of DAB which consists of senior management officials as well as clinical leaders. The Quality Board oversees monitoring activities most appropriate for determining quality of care at this facility, e.g. Healthcare Failure Mode and Effect Analysis and Root Cause Analysis, patient satisfaction, and quality control activities. They track utilization review activities, performance measures, develop and implement plans for continued accreditation body readiness for Joint Commission, OIG, CAP, etc., and ensures the uniform performance of patient care processes.

ARTICLE 9

MEETINGS

SECTION 1: MEDICAL STAFF MEETINGS

- A. Annual or semi-annual meetings will be held at the call of the Chief of Staff. The agenda will consist of medical and business items.
- B. The Medical Center Director or the Chief of Staff may call special meetings at any time.
- C. Attendance is mandatory for all Medical Staff meetings except in the event of an emergency. A quorum will consist of one-half of the members of the active staff; however, attendance at meetings called by the appropriate authority is expected.

Members of the medical staff will serve on other medical center committees, as assigned.

SECTION 2: ATTENDANCE REQUIREMENTS

Unless otherwise specified by policy, a quorum is considered 50% or one over half.

ARTICLE 10

RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations (not in conflict with requirements of Federal law) as may be necessary for the proper conduct of its work. Such Rules and Regulations shall be part of these Bylaws, except that they may be amended at any regular meeting without previous notice by a two-thirds vote of the members present. Fifty percent of the full and part-time staff constitutes a quorum. Such Rules and Regulations shall become effective when approved by Medical Center Management.

ARTICLE 11

AMENDMENTS

1. The Bylaws, Rules and Regulations are reviewed at least annually, revised as necessary to reflect current practices with respect to medical staff organization and functions; and dated to indicate the date of last review. These Bylaws may be amended or may be rewritten with such changes being adopted by the Medical Staff. Revised Bylaws will supersede and replace all previous Bylaws.
2. Written text of proposed significant changes is provided to Medical Staff members and others with clinical privileges with time for review and notice of date for formal consideration.
3. All changes to the Bylaws require action by both the Medical Staff and Medical Center Director. Neither may act unilaterally.
4. Changes become effective when approved by the Medical Center Director.

ARTICLE 12

ADOPTION

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the (active) Medical Staff; shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Medical Center Director.

ADOPTED BY THE MEDICAL STAFF ON December 2008

//s//

James Sanders, M. D.
Chief of Staff

ADOPTED BY THE MEDICAL CENTER DIRECTOR ON December 2008

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//s//

Kent D. Hill
Medical Center Director

RULES AND REGULATIONS

SECTION 1: PATIENT RIGHTS AND RESPONSIBILITIES

A. Equitable and humane treatment at all times and under all circumstances is a patient's right. Every individual who enters this hospital for care retains certain rights for privacy; not only the privacy of his/her body, but also the privacy of his/her disclosure. Therefore, all verbal or written disclosures of facts regarding a patient, other than to the family, guardian and authorized VA and congressional inquiries, will be handled through the Release of Information Section. All written communications must be cleared through this section.

B. The patient also has the right to communicate with those responsible for his/her care and receive from them adequate information concerning the nature and extent of his/her clinical problem, the planned course of treatment and the prognosis. Therefore, the patient will be an informed participant in the decisions and in the consideration of ethical issues that arise in the provision of his/her care.

C. Patient education and informed consent are an essential part of the patient's clinical record and must be clearly documented on the patient's chart.

D. This organization affirms the patient's right to make decisions concerning his/her medical care, including the decision to discontinue treatment to the extent permitted by law and to be informed of the medical consequences of his/her action. Patients have the right to accept or refuse any medical treatment or procedure recommended to them; thus, all treatments and procedures require the prior, voluntary informed consent of the patient, or if the patient lacks decision-making capacity, the patient's authorized surrogate. Considerate and respectful care will be provided that respects the patient's personal value and belief systems.

E. Patient rights and responsibilities are further detailed in Policy Memo 11-59.

SECTION 2: INFORMED CONSENT

A. The practitioner who will perform the treatment or procedure must ensure that the informed consent process outlined in the policy (Policy Memo 11-38) is followed. Informed consent should be obtained for all diagnostic and therapeutic procedures which:

1. Require the use of sedation,
2. Require narcotic analgesia or anesthesia,
3. Are considered to produce significant discomfort to the subject,
4. Have a significant risk of complication or morbidity,
5. Require injections of any substance into joint space or body cavity,

B. Informed consent is documented by appropriate completion of the IMED Consent and/or VA form (SF 522), "Request for Administration of Anesthesia and for Performance of Operations and other Procedures." (Refer to Policy Memo 11-38 for more details.) The VA form SF 522 will be used only in situations where it is not practical to use the IMED.

C. All properly executed consents will be considered valid for a period of thirty (30) calendar days. In the event of a significant change in the patient's condition, which might alter diagnostic or therapeutic decisions, the consent will be deemed to be automatically rescinded.

D. If the patient is unable to give consent and the party who has the authority to grant consent is not available or non-existent, authority may be granted by the Chief of Staff for emergency procedures.

SECTION 3: GENERAL RESPONSIBILITY FOR CARE

A. CONDUCT OF CARE

1. The management and coordination of each patient's care, treatment, and services is the responsibility of a practitioner with appropriate privileges, with communication among all practitioners and staff involved in the patient's care, treatment, and services. The details of conduct and responsibilities for care are in the Plan for Patient Care and all members of the medical staff shall abide by these responsibilities.

2. The same quality of care, treatment, and services will be provided to all patients across all services. To insure a uniform standard throughout the facility, there will be monitoring and evaluation and other performance assessment and improvement activities. The clinical privileging process will also establish comparability of services provided by the medical staff. For example, similar indicators will be used and similar criteria for similar privileges will be established.

3. All patients will receive a comparable level of quality of surgical and anesthesia care throughout the Medical Center. All patients who receive IM, IV or inhalation (nitrous oxide) sedation prior to undergoing an invasive procedure shall be managed in accordance with established guidelines. Clinical services on which invasive procedures are performed on sedated patients shall develop a system to grant clinical privileges to independent practitioners who provide sedation for invasive procedures. Invasive procedures include but are not necessarily limited to minor surgery procedures, dental procedures, percutaneous aspirations and biopsies, radiologic procedures, cardiac and vascular catheterizations and endoscopies. Monitoring and evaluation of the quality of surgical and anesthesia provided by individuals in any department/service of the hospital is conducted.

B. EMERGENCY SERVICES

1. This VA is a designated Level III Emergency Department which offers emergency care 24 hours a day, with at least one physician available to the emergency care area at all times. Specialty consultation is available by request of the attending medical staff member or by transfer to a designated hospital where care can be provided.

2. A physician is responsible for the degree of evaluation and treatment provided to any patient who presents himself/herself or is brought to the emergency department. The Triage RN will determine the priority with which a person seeking emergency care will be seen by a physician. The ER nurse will make a preliminary assessment as to whether the patient is emergent, urgent or non-urgent and notify the physician accordingly. Medical need is determined by a VA physician and will also classify the case emergent, urgent or general, as applicable.

SECTION 5: ADMISSIONS, DISCHARGES AND PATIENT CARE

A. Admission: Admitting is restricted to delegated appropriate House Staff or licensed physicians, dentists and osteopathic physicians who are appointed to attend patients. Patients may not be rejected from the system except by licensed physicians, dentists and osteopathic physicians.

All admitted patients must have appropriate, specific admitting orders, to include dietary orders entered in the patient's chart, upon admission.

Final authority for admission and assignment to a service rests with the admitting medical officer.

B. H&P: A history and physical examination shall be performed by a physician who has such privileges within 24 hours of admission. Physician's Assistants and Advance Practice Nurses may perform History & Physical Examinations and the findings, conclusions, and assessment of risk must be confirmed or endorsed by a qualified physician prior to major diagnostic or therapeutic intervention or within 24 hours whichever is first.

Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry and must be authenticated by a physician or when appropriate by a qualified oral/maxillofacial surgeon member of the medical staff.

A podiatrist with clinical privileges may, with the concurrence of an appropriate physician member of the Medical Staff, initiate the procedure for admitting a patient. The podiatrist is responsible for his/her part of the patient's history and physical examinations that relates to podiatry. The concurring Medical Staff member shall assume responsibility for the overall aspects of the patient care throughout the hospital stay. Patients admitted to the

Medical Center for Podiatric care must be given the same basic medical appraisal as patients admitted for other services. A physician member of the Medical Staff must be responsible for the care of any medical problem that may be present or may arise during the hospitalization of a Podiatric patient.

C. Patient Assignment: All patients will be assigned to care of a practitioner who is a member of the medical staff with appropriate privileges. This practitioner manages and coordinates the patient's general medical condition. The quality of care, treatment, and services is dependent upon coordination and communication of the plan of care and is given to all relevant health care providers to optimize resources and provide for patient safety. This member of the medical staff is responsible for the following:

1. Medical care, diagnostic evaluation, treatment and special instructions.
2. Management and coordination of the patient's general medical condition.
3. Communication among all practitioners involved in the patient's care, treatment and services.
4. Prompt completion and accuracy of the medical record.
5. Transmitting reports on condition of patients to family.
6. Entering an admission diagnosis in the medical record except in an emergency.

Although the day-by-day treatment of the patient, which includes writing patient care orders, may be delegated to appropriately supervised House Staff, the responsibility for patient care rests with the professional staff member. Whenever these responsibilities are transferred to another staff member or service, an order covering the transfer shall be entered on the order sheet of the medical record.

D Areas of Restricted Admission: Written criteria for admission to the special care units are established and approved by the medical staff along with admission, continued stay and level of care criteria.

E. Transfer of Patients:

1. Internal transfer of patients from one bed section to another will be made in accordance with Policy Memorandum 11-43.
2. Interfacility transfer of patients will be in accordance with Policy Memorandum 136-03.
3. Criteria for transfer
 - a. If diagnostic or therapeutic procedures and/or services that are medically indicated are not available at the VA Medical Center, such transfers require a consult entry and approval process according to policy. (Policy Memorandum 11-10; Policy Memorandum 11-110)

F. Consultation:

1. When operative procedures are involved, the consultation, except in an emergency, shall be reported prior to the operation
2. Consultant: A consultant must be well qualified to give an opinion in the field that an opinion is sought. The status of a consultant is determined by the medical staff on the basis of the individual's training and experience and competency. Resident staff may respond to consults but with appropriate supervision by the attending staff. All consultation notes should reveal the involvement of the appropriate staff as defined in the resident supervision policy (PM 11-24).
3. Responsibility for Consultation: The Service Chiefs will make certain that members of their staff provide timely and appropriate consultation as needed. Basic philosophy should be to provide consultation with a high level of professional competency, efficiency and promptness both for service to the patient and for educational purposes. Whenever possible, the clinical staff will answer consultations either individually or jointly with the resident.

4. Consultants may not write orders on patients of another medical staff member or service unless requested to do so. In the event that such orders are written, a counter-signature is required by the responsible medical professional of record, before implementation. Consultations do not represent referrals.

5. Initiating Consultation Requests: Consultation should be initiated by the staff member or by appropriately supervised House Staff. Inpatient consultations should be initiated utilizing the electronic consultation form in CPRS (Computerized Patient Record System). The electronic consult should be also utilized for outpatient consultation requests, where available. Consultation requests should be clear, well written, give full description of the problem, any types of interventions previously attempted and the information requested.

6. Good medical judgment should always be exercised in initiation of consultation requests in order to avoid overburdening the consulting section, department or individuals. Consultation should be requested for valid medical or educational reasons.

7. Responding to Consultation Requests: Routine electronic inpatient consultation requests will be responded to the next working day. For emergency or ASAP consultations, the provider will page the consultant or on-call consultant; emergency consultation requests will be acted upon within 30 minutes. Outpatient Consultation Requests will be responded to within the timeframe indicated by the VHA Directive 2006-055.

8. Medical ethics should be followed in consultations. The findings and opinions of the consultant should be limited to the clinicians involved. Patients should not be apprised or advised by the consultant except with the attending staff's prior knowledge and consent. Consultations require professional conduct of the highest magnitude.

9. If a nurse or any other professional has any reason to doubt or question the care provided to any patient and feels that appropriate consultation is needed and has not been obtained, he/she shall direct said question to the attending medical staff member. If after then, he/she still feels that the questions have not been resolved, it shall be called to the attention of the supervisor who will attempt to solve the problem through the chain of command.

G. Physician's Orders:

1. Only physician and dentist members of the medical staff may write free-standing (i.e., uncountersigned) orders when privileged to do so.

2. Medical orders will be entered in CPRS (Physician Order Entry). In the rare instance requiring handwritten orders, they must be timed, dated, legible and signed by the medical professional issuing the order before the instructions are executed.

3. All orders for treatment shall be entered in CPRS and signed by a medical staff member, house staff, or by other individuals within the authority of their clinical privileges and/or functional statement. Exceptions include the following circumstances:

a. In the management of emergency circumstances when the urgency of the clinical situation requires verbal orders, e.g. during cardiopulmonary resuscitation;

b. When written orders are not practical, e.g., when the staff member is gloved during a procedure requiring sterility and an order is required;

c. To care for a clinical problem when the responsible physician is out of the building.

4. Verbal/telephone orders will be discouraged (PSM-27). Only RNs, pharmacists, and respiratory therapists may accept and transcribe verbal orders. Verbal/telephonic orders will be acceptable only in emergent situations or when the medical professional directly involved with a given patient's care is outside the building and the telephonic orders are the most practical and expeditious means of continuing the patient's care at that time. The latter telephonic orders are acceptable only when the patient's clinical condition is such that the medical professional's personal attendance is not required or to cover the period

to allow him to arrive at the bedside. All telephonic orders shall be written down, read back for confirmation and will be entered on the order sheet. The notation will include the name and title of the issuing individual and the receiver. In all circumstances where verbal orders are given, they should be written in the chart, timed, dated, and authenticated within 24 hours of the verbal order.

H. Medication and Other Orders: Refer to the following policies:

1. PM 11-108
2. PM 119-01
3. PM 119-07
4. PM 119-10

I. Investigational Drugs (PM 119-12).

Investigational drugs are used only when approved by the Human Studies Committee and the Research & Development committee, administered under approved protocol with patient informed consent, and under the direct supervision of the authorized Principal Investigator. Investigational drugs are stored in and dispensed from the pharmacy. All activities pursuant to the obtaining of investigational drugs will be under the close scrutiny of the *Lead Pharmacist*, as a safeguard against unauthorized use of investigational drugs through borrowing from other hospitals and physician's use without adherence to protocol procedures, except as noted under humanitarian use.

J. Submission of Surgical Specimens:

Exceptions to sending specimens removed at surgery to the laboratory are developed by the medical staff services and approved by the Surgical Case Review Committee and by the ECMS. A detailed listing of these exceptions is outlined in hospital policy (PM 11-90).

K. Other Special Treatment and Procedures:

1. **DNR:** The roles of practitioners in decisions to withhold resuscitative services or forego or withdraw life-sustaining treatment are outlined in detail in a Medical Center memorandum (PM 11-25).
2. **Advance Directive:** Hospital policy (PM 11-61) addresses the use of advance directives in patient care to the extent provided by law
3. **Organ Donation:** Organ donation policy and procedures are established in a policy memorandum, PM 11-79.
4. **Incident Reporting:** In all instances in which there is reason to believe that a patient has been involved in an incident that either has harmed, or has the potential of causing harm to the individual, a factual description of that alleged incident should be reported on VAF 10-54 (589), Report of Special Incident, within 24 hours.

All incident reports should be forwarded to the Director through PPCI and the Chief of Staff. More specific guidance regarding reporting of special incidents is detailed in hospital Policy Memorandum 00-17.

5. **Use of restraints or seclusion:** Restraints are to be used only in clinically justified situations to reduce health and safety risks, while protecting the patient's rights and dignity. The use of restraints is based on specific assessment of the patient's needs and a physician's order. Patients in restraints require assessment and monitoring as required by Professional Services Memorandum No. 8, "Use of Restraints" and PSM 21.

L. Moderate (Conscious) Sedation and/or Anesthesia for Invasive Procedures:

All patients who receive intramuscular, intravenous or inhalation (nitrous oxide) sedation prior to undergoing an invasive procedure shall be managed as outlined in hospital memoranda (PSM 42). Invasive procedures include, but are not necessarily limited to, minor surgery procedures, dental procedures, percutaneous aspirations and

biopsies, radiologic procedures, cardiac and vascular catheterization, and endoscopies.

M. Discharge Planning: See Policy Memorandum 11-27

SECTION 5: ROLE OF THE ATTENDING STAFF/RESIDENT SUPERVISION

All members of the medical staff must be in compliance with the resident supervision policy (PM 11-24). Compliance monitoring will be done on a monthly basis and >85% compliance is expected except in unusual circumstances.

SECTION 6: MEDICAL RECORDS

A. Basic Administrative Requirements

1. Medical Records will be maintained electronically. All staff should read electronic mail, consults, CPRS view alerts, and other important correspondence in a timely manner.
2. Only approved VA abbreviations and symbols may be used as according to Policy Memorandum 11-22 - Use of Abbreviations and Symbols.

B. Medical Record Requirements:

1. Details of Medical Record Requirements are specified in Policy Memorandum 136-01 and Policy Memorandum 136-09.
2. The following are authorized to make entries in the clinical record: privileged members of the Medical Staff; physician assistants; residents/fellows; clinical nursing personnel; medical, dental and nursing students; social workers; pharmacists; allied health trainees in areas such as Psychology, Audiology and Social Work; Occupational Therapists, Recreational Therapists, Respiratory Therapists, Physical Therapists; Addiction Therapists, Dieticians, Chaplains, technicians in Radiology; and, on rare occasions, the Patient Representative, and as so designated by the Service Chiefs. Entries made by these individuals will contain pertinent, meaningful observations and information. Medical record staff may be authorized to insert a "template" note in the medial record to advice users about the existence of an advanced directive.
3. For medical, legal, and billing purposes, a medical student note, even if counter-signed, cannot "stand alone". An addendum should be attached or an independent attending note written to show that an independent evaluation of the patient was conducted and a management plan developed.
4. For inpatients, the H&P should be completed within 24 hours. If a complete physical examination has been completed 30 days prior to admission, it may be used provided there have been no changes subsequent to the original examination or the changes have been recorded at the time of admission and prior to the surgical procedure.
5. Medical records will be completed insofar as possible at the time of discharge including signature, discharge note, discharge diagnosis, operations performed and/or procedures. When completion of the discharge summary is not able to be completed at the time of discharge to a nursing home, an abbreviated template may be used as an interim measure. Discharge summaries must be dictated within a reasonable period following the discharge, but not to exceed five (5) days.
6. All records are the property of the VA Medical Center, Kansas City, Missouri, and can be removed from the premises only under court order, statute, subpoena or conditions consistent with VA regulations (M-1, Part I, Chapter 9).
7. Requests received from Release of Information will be completed in a timely manner.
8. Staff members who fail to complete their assignments, including records will be subject to disciplinary actions according to VA procedures in DVA Handbook 5021, Part II, Chapter 1.

9. Operating Room Record: Except in extreme emergencies, surgery is performed only after an appropriate history and physical examination, and appropriate laboratory and, if indicated, imaging, tests [and the preoperative diagnosis recorded in the medical record. The individual, who is responsible for the patient, authenticates and records a preoperative diagnosis prior to surgery. The record should contain pre-anesthesia, intra-operative and post-operative evaluation, monitoring and assessment which are documented by LIPs.

10. Operative Reports: Operative Reports are dictated immediately after (<24 hours) surgery. When the Operative Report is not placed in the medical record immediately after surgery, an operative progress note is entered immediately. The progress note contains at a minimum, a description of the findings, the technical procedures used, complications as appropriate, the specimen removed, the post-operative diagnosis, and the name of the primary surgeon and the name of any assistants. The VA level of staff supervision must also be so noted on the operative report. The completed operative report is authenticated by the surgeon and filed in the medical record ASAP.

C. The medical record requirements as defined cover all programs of this facility.

SECTION 7: HANDLING OF AUTOPSIES (See Policy PM 11-24)

SECTION 8: PROFESSIONAL EDUCATION

A program of continuing medical education is designed to keep the Medical Staff informed of significant new developments in medicine. Medical Staff education will include medical center based programs that are planned, scheduled in advance and held on a continuing basis as well as educational opportunities held outside of the medical center. This continuing education should be documented in the medical staff member's file.

SECTION 9: GUIDELINES FOR INITIATING RESEARCH, SCIENTIFIC AUTHORSHIP, PRESENTATION, AND PUBLICATION

A. Before any research project is started at the Kansas City VA Medical Center, it must first be reviewed and approved by the Research and Development Committee (PM 151-01). If the research involves human subjects, the Human Studies Committee must also review it (PM 151-02). Research should be discussed and approved by the Service Chief and concurrence from the Chief of Staff prior to beginning research projects (PM 11-109)

B. To ensure that proper criteria for establishing authorship and VA procedures are followed for presentation and publication of scientific data, provisions of Policy Memo 11-112: Scientific Authorship, Presentation, & Publication will be followed.

SECTION 10: INFECTION CONTROL

A. Isolation/Standard Precautions: There is an effective hospital-wide program for surveillance, prevention and control of infection. It is the responsibility of all medical staff members, hospital personnel, students and volunteers who come in contact with any blood or body fluid secretions from patients to take the necessary precautions to prevent the possibility of contamination due to direct exposure. Specific policies and procedures are established and approved by the medical staff. It is the responsibility of each medical staff member to be knowledgeable and follow guidelines as defined.

B. HIV. HIV testing and pre and post counseling will be conducted in accordance with Public Law 100-322 as defined in Circular 10-88-151 and in accordance with Medical Center Policy Memorandum 11-34.

C. Reportable Cases: This Medical Center will report disease as specified by the Missouri Department of Health when the diagnosis is established. The diseases that must be reported are outlined in Policy Memorandum 11-96. The physician will notify the Infection Control Nurse when a known or suspected reportable disease diagnosis is confirmed so that proper reporting will occur.

SECTION 11: DISASTER PLAN

Local/National: Disaster plans and staff responsibilities and the VA/DOD Contingency Plan are outlined in detail in the "Emergency Preparedness Plan." It is the medical staff's responsibility to become knowledgeable of this plan. Mass casualty assignments for physicians will contain the assignment to posts within the Medical Center and it is his/her responsibility to report to the assigned station when needed. The Chief of Staff and Director will work as a team to coordinate activities and direction. In cases of evacuation of patients from one section of the Medical Center to another or evacuation from Medical Center premises, the Chief of Staff, during the disaster, will authorize movement of patients as directed by the Director or his/her designee.

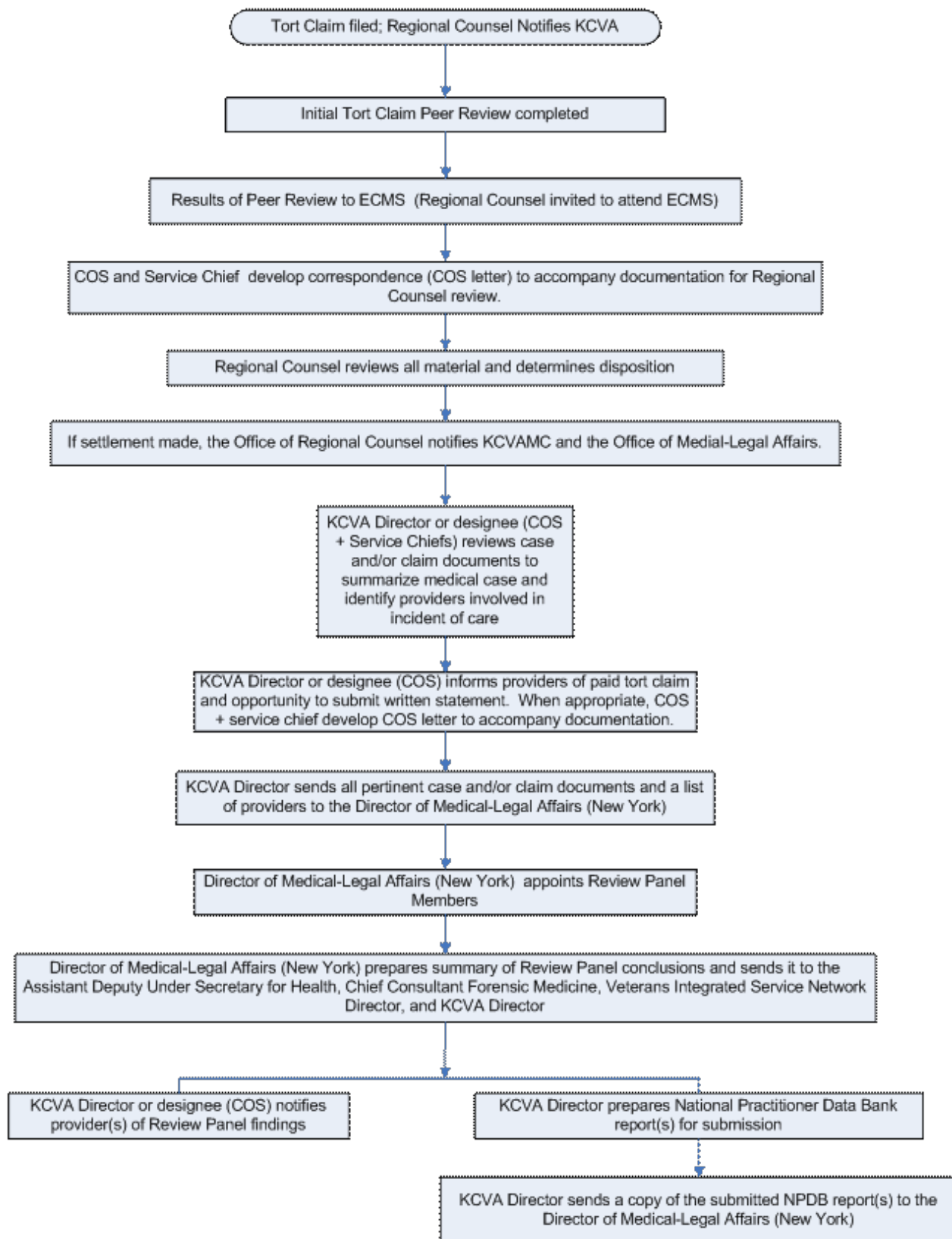
SECTION 12: IMPAIRED PROFESSIONAL PROGRAM

Employee Assistance Program: Management recognizes that substance abuse; adjustment problems, behavioral disorders and mental health problems are illnesses that can be successfully treated. Employees with these problems will be given the same consideration and offer of assistance extended to employees with other health problems. Referral to EAP is separate from and should not be regarded as part of a disciplinary process. Referral is strictly for the purpose of providing needed assistance to employees. This medical center has designed a process that provides education about licensed independent practitioners (LIP) health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis treatment, and rehabilitation of LIPs who suffer from a potentially impairing condition. All employees should report if they suspect that an LIP is impaired. Refer to Policy Memorandum 11-52.

SECTION 13: POLICY MEMORANDA

Medical Center memoranda are considered an extension of the Rules and Regulations. They are available to all staff directly, through service chiefs, on the VA Medical Center's intranet site, and from the office of the Chief of Staff. They are available to prospective staff for review upon request.

TORT CLAIM PROCESS KANSAS CITY VAMC



MEDICAL STAFF BYLAWS

DEPARTMENT OF VETERANS AFFAIRS
4801 E. Linwood Boulevard
Kansas City, Missouri 64128-2226

THIS IS TO CERTIFY THAT I HAVE RECEIVED A COPY OF, HAVE BEEN ORIENTED TO, REVIEWED, UNDERSTAND, AND HEREBY AGREE TO ABIDE BY, THE CURRENT **MEDICAL STAFF BYLAWS**. I ALSO AGREE TO PROVIDE CONTINUOUS CARE FOR PATIENTS ASSIGNED TO ME, AND ARRANGE FOR THE TRANSFER OF CARE AS APPROPRIATE IN ACCORDANCE WITH MEDICAL CENTER AND VHA RULES AND REGULATIONS.

Please Print Your Name, Sign, and Return to Chief of Staff Office (11)

Signature

Date

Printed Name: