

**VA EASTERN KANSAS
HEALTH CARE SYSTEM**

**BYLAWS AND RULES
OF THE
MEDICAL STAFF**

September 10, 2009

**THE DWIGHT D. EISENHOWER VA MEDICAL CENTER,
LEAVENWORTH DIVISION, AND
THE COLMERY-O'NEIL VA MEDICAL CENTER,
TOPEKA DIVISION AND
ALL ASSOCIATED COMMUNITY-BASED OUTPATIENT CLINICS**

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BYLAWS AND RULES OF THE MEDICAL STAFF OF THE VA EASTERN KANSAS HEALTH CARE SYSTEM

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

PREAMBLE

Recognizing that the Medical Staff is responsible for the uniform quality of patient care, treatment, and services delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing in VA Eastern Kansas Health Care System (VAEKHCS), hereby organize themselves into a single, organized body for self governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs (VA) and the *Bylaws and Rules* hereinafter stated. The development, maintenance, and compliance with medical staff *bylaws* are primarily functions of the Organized Medical Staff. These *Bylaws and Rules of the Medical Staff* are consistent with all laws and regulations governing the VA, and they do not create any rights or liabilities not otherwise provided for in law or VA regulations.

DEFINITIONS

1. *Bylaws and Rules of the Medical Staff*

The term “Bylaws” refers to the rules and regulations governing the internal affairs of an organization; the *Bylaws* in this document govern the Medical Staff of the VAEKHCS. The term “Rules” refers to the specific guidelines, set forth in this document, which govern the Medical staff of the VAEKHCS. It does not refer directly to formally promulgated federal or VA regulations. The *Bylaws and Rules of the Medical Staff* provide guidance to Medical Staff to assist them in meeting the expectations of VAEKHCS and to comply with requirements of the VA and external accrediting bodies.

2. VA Eastern Kansas Health Care System (VAEKHCS)

VAEKHCS is a single organization and is comprised of the Dwight D. Eisenhower VA Medical Center, Leavenworth, Kansas, the Colmery-O'Neil VA Medical Center, Topeka, Kansas, and all associated community-based outpatient clinics.

3. Medical Staff

The Medical Staff is defined as all fully licensed physicians, dentists, podiatrists, optometrists and psychologists who provide patient care services independently and who are authorized by law and by the VAEKHCS to diagnose, treat, admit and/or discharge patients in VAEKHCS; and all properly qualified physician assistants, advanced practice registered nurses (nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists) and clinical pharmacy specialists who provide patient care services interdependently (with physician supervision) in VAEKHCS. The medical staff is organized as a single entity known as the Medical Staff, with four (4) categories of members as outlined in Article III, Section 2.

4. Governing Body

The term "Governing Body" refers to the Under Secretary for Health, the individual to whom the Secretary of the VA has delegated authority for administration of the Veterans Health Administration (VHA). For purposes of local facility management and planning, it refers to the Director of VAEKHCS.

5. Director, VAEKHCS

The Director is appointed by the Secretary of the VA as the Governing Body to act as its agent in the overall management of VAEKHCS. The Director is assisted by the Chief of Staff, the Associate Director and the Associate Director for Patient Care Services/Nurse Executive.

6. Chief of Staff

Appointed by the Under Secretary for Health, the Chief of Staff, a licensed and properly qualified physician, is the Chief Medical Officer and permanent President of the Medical Staff. The Chief of Staff is responsible for ensuring that a high standard of medical care is maintained in all clinical matters pertaining to the clinical staff, medical management and coordination of patient care, research, education, and allied health care activities in the VAEKHCS. In the absence of the Chief of Staff s/he assigns an Acting, Chief of Staff (a properly qualified physician member of the Medical Staff) to act in his/her behalf.

7. Medical Executive Board

The term "Medical Executive Board (MEB)" refers to a core committee of the Medical Staff. It is empowered by the Medical Staff to conduct business and make recommendations on behalf of the Medical Staff on clinical matters as defined in the *Bylaws and Rules*

8. Professional Standards Board

The term "Professional Standards Board (PSB)" refers to a sub-committee of the MEB which is delegated authority by the Governing Body to render decisions on Medical Staff initial

appointment, reappointment, and renewal or modification of clinical privileges. Recommendations of the PSB are made directly to the Director of VAEKHCS. PSB is chaired by the Chief of Staff, who appoints members as needed, usually from MEB, the PSB functions as outlined in these *Bylaws and Rules* and VA regulations. In addition to appropriate professional members of the PSB, a technical advisor from Human Resources may be invited to serve on the PSB to assist with applicable personnel regulations.

9. Licensed Independent Practitioners, Mid-Level Practitioners, and Other Practitioners

a. Licensed Independent Practitioners (LIPs)

An LIP is an individual who is permitted by law (the statute which defines the terms and conditions of the practitioners license) and by the facility to provide patient care services independently; i.e., without direction or supervision, within the scope of the individual's license and in accordance with individually-granted clinical privileges.

b. Mid-Level Practitioners

In VAEKHCS, there are three types of Mid-Level Practitioners: Physician Assistant (PA), Clinical Pharmacy Specialist (CPS), and Advanced Registered Nurse Practitioner (ARNP). The ARNP category also includes Clinical Nurse Specialists, Nurse Midwives, and Nurse Practitioners and Certified Registered Nurse Anesthetists who have Masters or Doctoral degrees. ARNP are sometimes referred to Nurse Practitioners (NP) and Advanced Practice Nurses (ANP). These Practitioners serve in an interdependent role with a physician supervisor. Their scope of practice is limited by the privileges granted and the restrictions of their state of licensure or registration. These providers do not independently practice. Prescriptive authority is allowed and must follow the guidelines set by their state of licensure or registration. Each midlevel practitioner has a scope of practice based on qualifications and current competence, recommended by the individual's supervising physicians, Service Line Manager, PSB, MEB, and appointed by the Director. Mid-levels do not admit or discharge patients unless specifically authorized by scope of practice under the direct supervision of a physician. Mid-level practitioners are Category IV members of the Medical Staff.

c. Other Licensed or Certified Practitioners

In VAEKHCS, properly qualified registered nurses, licensed audiologists, registered pharmacists, registered dietitians, licensed social workers, registered physical therapists/occupational therapists, speech therapists, qualified addiction counselors, and other allied health professionals with registration/licensure/certification practice within the framework of their licensure/certification and within their functional statements or position descriptions. For purposes of these *Bylaws and Rules*, they are not considered LIPs, although they may perform certain "extended" medical care functions and patient care duties without direct Medical Staff oversight when carrying out functions consistent with their approved

scopes of practice/functional statements/job descriptions. These providers are not members of the Medical Staff.

10. Service Lines

VAEKHCS is organized according to the following Service Lines: Medicine, Behavioral Health, Diagnostic Care, Surgery and Surgical Specialties, Geriatrics and Extended Care, Pharmacy, Social Work, Nursing, Clinical Support, Information Management, Business Office, Finance, Engineering, and Environmental & Safety Service. For purposes of these *Bylaws and Rules*, Medical Staff are organized into or associated with the clinical service lines.

11. Medical Staff Service Line Managers

A clinical Service Line Manager is a Medical Staff member who has the education, knowledge, and experience and is appointed to a leadership and management position, specifically in the areas of Medicine, Behavioral Health, Diagnostic Care, Surgery and Surgical Specialties, and Geriatrics and Extended Care.

12. Consultant

A Consultant is a licensed and properly qualified physician, dentist, podiatrist, optometrist or psychologists who provide consultative services to or in the VAEKHCS, including telemedicine services. Members of the Medical Staff of the VAEKHCS may provide consultation to other members of the Medical Staff. Refer to the Rules, Section C. (General Responsibility for Care), paragraph 6, (Consultations), of this document. A Consultant may be from the private-sector, an affiliated medical school/teaching hospital, or other organization outside the VA. Consultants are subject to VA regulations and VA credentialing and privileging procedures. They may participate in graduate medical education, lecturing or teaching resident physicians, and may serve as supervising physicians for resident trainees. Consultants from outside the VA are Category III members of the Medical Staff.

13. Contract Medical Staff

Pursuant to a Contract or through a Fee Basis arrangement with the VA, a properly credentialed/privileged Contract physician, dentist, podiatrist, optometrist or psychologist may provide patient care services VAEKHCS. They are Category III members of the Medical Staff. ARNP, PA, and CRNA services may be contracted to provide care to Veterans. These individuals are Category IV medical staff members.

14. Appointment

As used in this document, the term refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee (unless clearly specified), but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority

for providing patient care services at VA EKHCS. Both VA employees and contractors may receive appointments to the Medical Staff. An appointment to the medical staff is achieved through the credentialing process, privileging process, and appointment by the Director.

15. Associated Health Professional

The term Associated Health Professional is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine.

16. Credentialing and Credentials

a. Credentialing

The term "credentialing" refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, and current competence and health status.

b. Primary Source Verification

Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be documented in the form of a letter, documented telephone contact, or secure electronic communication with the original source.

17. Clinical Privileging and Clinical Privileges

The term "clinical privileging" is defined as the process by which a practitioner, licensed for independent practice (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.), is permitted by law and VAEKHCS to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure. Clinical privileges must be VAEKHCS-specific and provider-specific.

18. Authenticated copy

The term authenticated copy means that each page of the document is a true copy of the original document; each page is stamped "authenticated copy of original" and is dated and signed by the person doing the authentication.

19. Competency

Competency is documented demonstration of an individual having the requisite or adequate abilities or qualities capable to perform up to a defined expectation.

20. Current

The term “current” applies to the timeliness of the verification and use for the credentialing and privileging process. No credential is current and no query of the Federation of State Medical Boards (FSMB) is current if performed prior to submission of a complete application by the practitioner to include submission of VetPro. At the time of initial appointment, all credentials must be current within 180 days of submission of a complete application. For reappointment, all time-limited credentials must be current within 180 days of submission of the application for reappointment including peer appraisals, confirmation of National Practitioner Data Bank (NPDB), Health Integrity and Protection Data Bank (HIPDB), Proactive Disclosure Service (PDS) annual registration, and other credentials with expirations.

21. Licensure

The term “licensure” refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State, Territory, Commonwealth, or the District of Columbia (hereafter, “State”) in the form of a license, registration, or certification.

22. One Standard of Care

The term “one standard of care” means that one standard of care must be guaranteed for any given treatment or procedure, regardless of the practitioner, service, or location within VA EKHCS. In the context of credentialing and privileging, the requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same.

23. Post-graduate (PG)

24. Proctoring

Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations. The proctor must have clinical privileges for the activity being performed, but must not be directly involved in the care the observed practitioner is delivering. Proctoring that requires a proctor to do more than just observe, i.e., exercise control or impart knowledge, skill or attitude to another practitioner to ensure appropriate, timely, and effective patient care, constitutes supervision. Such supervision may be a reduction of privileges.

25. Teleconsulting

Teleconsulting is the provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance

separates the participants, and where hands-on care is delivered at the site of the patient by a licensed independent health care provider.

26. Telemedicine

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

27. VetPro

VetPro is an Internet enabled data bank for the credentialing of VHA health care providers that facilitates completion of a uniform, accurate, and complete credentials file. VetPro is the official record of the credentialing process.

28. Joint Commission (JC)

Is the accrediting body for the health care system.

BYLAWS OF THE MEDICAL STAFF

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of VA Eastern Kansas Health Care System.

ARTICLE II. PURPOSE

The purpose of the Medical Staff shall be to strive to:

1. Ensure that all patients treated at VAEKHCS (the Dwight D. Eisenhower VA Medical Center in Leavenworth, Kansas; the Colmery-O'Neil VA Medical Center in Topeka, Kansas; and all associated community-based outpatient clinics and outreach services), will receive efficient, timely, appropriate, quality health care services;
2. Ensure provision of the same level of care to all patients being treated for the same health problem or with the same methods/procedures by members of the Medical Staff;
3. Participate in educational activities that relate to the provision of care quality review activities and the expressed educational needs of the Medical Staff;

4. Develop and follow VAEKHCS-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges, within the framework of VA regulations;
5. Assist the Governing Body in developing and maintaining Bylaws and rules for Medical Staff self-governance and oversight;
6. Assure that issues concerning the Medical Staff and the VAEKHCS are discussed with the Director;
7. Establish and assure adherence to high ethical standards of professional practice and conduct;
8. Ensure a high level of professional performance of Medical Staff through quality improvement and appropriate delineation of clinical privileges and scopes of practice; and
9. Promote appropriate educational opportunities which strengthen scientific standards and lead to continuous advancement in professional knowledge and skill; encourage Medical Staff to participate in continuing medical education; and inform Medical Staff of developments which refresh and update their medical education.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege that shall be extended to qualified and competent physicians, dentists, podiatrists, optometrists, psychologists, physician assistants, ARNPs (NPs, APNs, CNSs, and CRNAs), clinical pharmacy specialists, and radiology assistants who continuously meet the qualifications, standards and requirements of VHA, VAEKHCS and these *Bylaws*. Except as defined in these *Bylaws*, membership may be considered for other licensed individuals who are permitted by law to provide patient care services.

Section 2. Categories of Medical Staff Membership

There are four categories of Medical Staff membership: Categories I, II, III, and IV, all considered active Medical Staff.

1. Category I

These members are full-time, salaried physicians, dentists', podiatrist, optometrists and psychologists staff of the VAEKHCS. They may engage in outside professional practice only in accordance with VA regulations. They shall be appointed to a specific service/line or section of a service/line to provide patient care, emergency service and consultations, or to provide education, research or administrative duties. They shall serve on Medical Staff committees and shall attend assigned Medical Staff meetings unless formally excused. They are voting members

in meetings of the organized Medical Staff may become MEB members and/or provide input to any MEB member or representative regarding medical issues at the VAEKHCS.

2. Category II

These members are part-time physicians, dentists, podiatrists, optometrists and psychologists receiving compensation for part time employment in the VAEKHCS. They may be regular part-time or intermittent part-time. They shall be appointed to a specific service/line or section of a service/line to provide patient care, emergency service and consultations, or to provide education, research or administrative duties. They are expected to arrange for or provide continuity of care to their patients and shall serve on Medical Staff committees. These members are strongly encouraged to attend meetings of the organized Medical Staff; however, attendance shall not be mandatory due to the part-time or intermittent nature of their presence in the VAEKHCS. They are eligible for Medical Staff offices, and are voting members in meetings of the organized Medical Staff.

3. Category III

These members are consulting, attending, on-station fee basis, on-station contract, on-station sharing agreement, or without-compensation physicians, dentists, podiatrists, optometrists and psychologists members who provide patient care, education, or research services. They shall be appointed to a specific service/line or section of a service/line. They shall not be required to attend Medical Staff meetings, are not eligible for Medical Staff offices, and are non-voting members of the Medical Staff. They may be eligible for appointment to Medical Staff committees.

4. Category IV

These members are mid-level practitioners. In VAEKHCS, mid-level practitioners are PAs, ARNPs (NPs, CNSs, and CRNAs), and clinical pharmacy specialists. They shall be appointed to a specific service line or section of a service line. They are non-voting members of the Medical Staff. They may be eligible for appointment to Medical Staff committees. One mid-level provider will be part of the MEB committee.

5. Non-members

- a. Physician and dentist trainees, also known as the house staff or resident staff, who are engaged in an approved course of graduate medical/dental education at the VAEKHCS, with or without compensation, are not considered members of the Medical Staff. Similarly, podiatry and optometry residents are not members of the Medical Staff. Resident trainees are appointed for a limited period of training, subject to the regulations of VHA. They shall not hold Medical Staff offices and are not eligible to vote at Medical Staff meetings. They shall be given the opportunity to contribute to discussions in Medical Staff committees where decisions will affect their activities, and may participate in Medical Staff conferences,

seminars, and teaching programs. All medical and dental care provided by residents must be under the preceptor-ship and supervision of a physician or dentist. The same is true for podiatry and optometry trainees. Residents are given clinical practice rights, including the writing of patient care orders, based on their level of training as determined by the VA residency program director(s). All medical and dental institutional/programmatic affiliations must be sanctioned by proper authorities in the VA and by the proper academic institutions.

b. Allied health professionals such as audiologists, registered nurses (non-advanced practice), pharmacists (non-advanced practice), social workers, physical and occupational therapists are not members of the Medical Staff. Their practice is based on approved scopes of practice, functional statements, or position descriptions.

Section 3. Non-discrimination in Medical Staff Membership

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

Section 4. Qualifications for Medical Staff Membership and Clinical Privileges

To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements must submit evidence of:

1. **Licensure:** Physicians, dentists, podiatrists, optometrists and psychologists must possess current, active, full and unrestricted license to practice his/her profession in a State, Territory or Commonwealth of the U.S. or the District of Columbia. Failure on the part of the practitioner to request, in a timely way, renewal of at least one state license, resulting in a lapse of license, precludes Medical Staff membership and clinical practice. The failure to maintain licensure in at least one state, commonwealth, or territory of the U.S. is grounds for loss of clinical privileges, Medical Staff membership and employment or contractual status. Mid-level practitioners (ARNP, CPS, and PA) are under the same requirements. Exceptions are PAs employed prior to March 12, 1993, when certification was not mandatory for VA employment.
2. **Education:** Education must be applicable to individual Medical Staff members as defined, e.g., an individual must hold a degree of Doctor of Medicine, Osteopathy, Dentistry, Podiatry, Optometry, or Psychology from an approved college or university, or other educational requirements appropriate to mid-levels as outlined in VHA policy. ARNP must hold a Masters degree in nursing. CPS are graduate PharmDs. PA must have graduated from an accredited program.
3. **Clinical Training and/or Experience:** The individual must provide evidence of relevant, documented clinical training and/or experience consistent with professional assignment and

privileges requested. This includes documented evidence of internships, residencies, board certification or specialty training and competence, which is performance based.

4. **Current Competence:** The individual must be able to show documented evidence of current competence, consistent with the professional assignment and privileges requested.

5. **Past Professional Competence and Conduct:** The individual must be able to provide documented and satisfactory findings relative to previous professional competence and professional conduct.

6. **Health Status:** There must be documentation of the individual's health status, consistent with physical and mental capability for satisfactorily performing Medical Staff duties and the assignment inherent within the requested clinical privileges. Completion of the Declaration of Health form must meet VA guidelines.

7. **Proof of Professional Liability Insurance:** Individuals who provide service under specialty contracts must provide current evidence of professional liability insurance as required by federal and VA requirements, as applicable.

8. **English-language Proficiency:** The individual must show the ability to communicate in spoken and written English with patients and health care personnel with sufficient fluency to satisfactorily carry out assigned responsibilities.

9. **Complete Information:** The individual must provide complete information consistent with requirements for application and clinical privileges, as defined in Articles IV and/or V of these *Bylaws*.

10. **Response-Time Criteria and Accessibility:** The individual must reside in a geographic location that allows on-call responsiveness, and must be accessible to VAEKHCS within specific time frames. Those individuals providing back-up on-call duties must be available via telephone within 15 minutes of being contacted. Those on-call Medical Staff who are required to be physically present in a specified medical center or outpatient clinic of the VAEKHCS must be available on site within one hour from the time of contact.

Section 5. Basic Responsibilities of Medical Staff Membership

Medical Staff members are accountable for and have responsibility to:

1. Provide for continuous care of patients assigned to their care.
2. Be knowledgeable and capable of providing age-specific care to patients.
3. Observe the rights of patients in all patient care activities.

4. Participate in continuing education, peer review, medical staff monitoring and evaluation.

At a minimum, physicians, dentists, podiatrists, optometrists, psychologists should complete the number of hours of continuing medical education (CME) sufficient to meet the requirements for individual state re-licensing. Mid-level practitioners are required to meet the continuing education requirements of their licensure or certification organizations. Non-certified PAs employed prior to March 12, 1993, shall meet the same continuing education requirements as their peers who are certified or licensed.

5. Physicians who supervise mid-level practitioners have responsibility of oversight of services provided by the mid-level provider, including participation in quality of care reviews. Mid-level practitioners have responsibilities for regular, periodic, professional communication with the physicians who provide their supervision.

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

- a. Abide by federal law and VA rules and regulations regarding financial conflict of interest and outside professional activities for remuneration.
- b. Abide by the Code of Ethics established by each Medical Staff member's profession, and contribute to high standards of ethics in all spheres of professional practice and conduct.
- c. Provide care to patients within the scope of privileges granted by the VAEKHCS. Inform the Director, through the Service Line Manager and Chief of Staff, of any change in his/her ability to fully meet the criteria for Medical Staff membership or to carry out clinical privileges that are held.
- d. Inform the Director, through the Service Line Manager and Chief of Staff, of any challenges or claims against professional credentials, licensure, professional competence or professional conduct within three (3) days of such occurrence, consistent with requirements for appointment under Article IV of these *Bylaws*.
- e. Advise the Director immediately, in writing, through the Service Line Manager and Chief of Staff, of any change in mental or physical health status that would alter his/her capability of satisfactorily performing Medical Staff duties within granted clinical privileges.

7. Abide by the *Bylaws and Rules of the Medical Staff* and all other lawful standards, rules, regulations and policies of the VAEKHCS and the VA.

ARTICLE IV. APPOINTMENT AND INITIAL CREDENTIALING

Section 1. General Provisions

Health care professionals must be fully credentialed and privileged prior to initial appointment or reappointment. Details of Credentialing and Privileging are in Handbook 1100.19.

Section 2. Procedure

1. VetPro is the electronic tool used for credentialing and privileging and is the official documentation of the credentialing process.
2. A 6-Part folder will be used to maintain paper documentation.
3. The Service Line is responsible for providing information to Credentialing to open a VetPro file.
4. The credentialing process includes:
 - Current and past licensure and/or certification, as appropriate, verified with the primary source
 - The applicant's specific relevant training, verified with the primary source
 - Evidence of physical ability to perform and requested privileges
 - Data from the professional practice review by an organization that currently privileges the applicant (if available)
 - Peer and/or faculty recommendation
 - Review of practitioner's performance within the hospital
 - A statement that no health problems exist that could affect his or her ability to perform the privileges requested.
 - National Practitioner Data Bank is queried.
 - Peer recommendations include:
 - a. Medical/clinical knowledge
 - b. Technical and clinical skills
 - c. Clinical judgment
 - d. Interpersonal skills
 - e. Communication skills
 - f. Professionalism
5. The applicable service chief reviews the credentialing folder and requested privileges and makes recommendations regarding appointment. The folder and recommendations are reviewed by the PSB and reviewed by the Medical Executive Board and recommended to the Director for appointment.
6. All applicants applying for clinical privileges must be provided with a copy of the Medical Staff Bylaws, Rules, and Regulations and must agree in writing to accept the professional obligations reflected therein.

7. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of 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 questions concerning these qualifications. Failure to provide necessary information, in a reasonable time frame, may serve as a basis for denial of medical staff appointment and/or privileges, as defined in the VA EKHCS Medical Staff Bylaws.

Section 3. Application Forms

1. Candidates seeking appointment or reappointment must complete the appropriate forms for the position for which they are applying.

- a. All candidates, requiring credentialing in accordance with this policy, must complete an electronic submission of VetPro. VetPro's supplemental information form requests applicants to answer questions to meet JC and VHA requirements. This supplemental information form requires the applicant to provide information concerning malpractice, adverse actions against licensure, privileges, hospital membership, research, etc.
- b. The "Sign and Submit" screen in VetPro addresses the applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for VA EKHCS, as well as attesting to the accuracy and completeness of the information submitted.
- c. An applicant is required to provide information on all educational, training, and employment experiences, including all gaps greater than 30 days in the candidate's history.
- d. Verification of a time-limited credential cannot be greater than 120 days old at the time a practitioner reports for duty.
- e. Once the VetPro file is opened, the applicant must input their data into their file in a timely manner. Other materials sent to the applicant will be completed and returned to VA EKHCS for entry into the VetPro system or the Credentialing Folder. Material to be returned include:
 - Application
 - Declaration of Health
 - Attestation to the Medical Staff Bylaws
 - Signed consent form
 - Clinical privileges being requested
 - Current clinical privileges held at other institutions
 - Continuing Medical Education (CME)
 - BLS and or ACLS certificate, as appropriate
 - Airway/intubation certificate
 - Current picture from:

- a. Current Hospital ID card
- b. A valid picture ID issued by a state or federal agency (e.g., driver's license or passport) (From JC)

Section 4. Documentation Requirements

1. Each privileged health care practitioner must have a Credentialing and Privileging file established electronically in VetPro with any paper documents maintained according to the requirements of the standardized folder. Other credentialed health care providers have a credentials file maintained in the same system of records even though they may not be granted clinical privileges. VetPro is the official credentialing file.
2. Information obtained, to be used in the credentialing process, must be primary source verified (unless otherwise noted) and documented in writing, either by letter, report of contact, or web verification.
3. There must be follow-up of any discrepancy found in information obtained during the verification process. The practitioner has the right to correct any information that is factually incorrect by documenting the new information with a comment that previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the practitioner says the information provided is factually incorrect.
4. Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and for informing the VA EKHCS Director, or designee, of any changes in the status of these credentials. The Program Chief Officer, or designee, is responsible for establishing a mechanism to ensure that multiple licenses, registrations, and/or certifications are consistently held in good standing or, if allowed to lapse, are relinquished in good standing. The practitioner is required to provide a written explanation for any credentials that were held previously, but which are no longer held, or are no longer full and unrestricted.

Section 5. Educational Credentials

1. Verification of Educational Credentials
 - a. For health care professionals who are requesting clinical privileges, primary source verification of all residencies, fellowships, advanced education, clinical practice programs, etc., from the appropriate program director or school is required. If a physician or dentist participated in an internship(s) equivalent to the current residency years PG 1, 2, and 3, it will be necessary to obtain primary source verification of the internship(s). Any fees charged by institutions to verify education credentials are to be paid by VA EKHCS.
 - b. For foreign medical school graduates, VA EKHCS officials must verify with the Educational Commission for Foreign Medical Graduates (ECFMG) that the applicant has met

requirements for certification, if claimed. The ECFMG is not applicable for graduates from Canadian or Puerto Rican medical schools. Documentation of completion of a “Fifth Pathway” may be substituted for ECFMG certification. Additionally, JC accepts the primary source verification of ECFMG for foreign medical school graduation. Documentation of this verification must meet the requirements of this policy.

- c. All efforts to verify education must be documented if it is not possible to verify education, e.g., the school has closed, the school is in a foreign country and no response can be obtained, or for other reasons. In any case, VA EKHCS officials must verify and document that candidates meet appropriate VA qualification standard educational requirements prior to appointment as an employee.
- d. Applicants are required to provide information on all educational and training experiences including all gaps greater than 30 days in educational history. Primary source verification must be sought on medical, dental, professional school graduation, and all residency(ies) and fellowship(s) training, as well as internships for non-physician, non-dentist applicants.
- e. An educational institution may designate an organization as its agent for primary source verification for the purposes of credentialing. The verification from the agent is acceptable (e.g., National Student Clearinghouse). Documentation of this designation needs to be on file.
- f. For other health care providers, at a minimum, the level of education that is the entry level for the profession or permits licensure must be verified, as well as all other advanced education used to support the granting of clinical privileges, if applicable (e.g., for an APRN, the qualifying degree for the registered nurse (RN) and the advanced APRN education must be verified).
- g. Primary source verification of other advanced educational and clinical practice program is required if the applicant offers this credential(s) as a primary support for requested specialized clinical privileges.
- h. Facilities may obtain, from the American Medical Association (AMA) or the American Osteopathic Association (AOA) Physician Database, a profile listing of all medical education a physician candidate has received in this country.

Section 6. Verifying Specialty Certification

1. Physician Service Chiefs

- a. Physician service chiefs must be certified by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty(ies) not appropriate for the assignment, the Medical Executive Board affirmatively

establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the Service Chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. Appointment of Service Chiefs without board certification must comply with the VHA policy for these appointments as appropriate.

b. Verification must be from the primary source by direct contact or other means of communication with the primary source, such as by the use of a public listing of specialists in a book or Web site, or other electronic medium as long as the listing is maintained by the primary source and there is no disclaimer regarding authenticity. If listings of specialists are used to verify specialty certification, they must be from recently issued copies of the publication(s), and include authentic copies of the cover page indicating publication date and the page listing the practitioner. This information must be included in the practitioner's folder.

2. Physicians. Board certification may be verified through the Official ABMS Directory of Board Certified Medical Specialists, published by the American Board of Medical Specialists (ABMS), or acceptable Internet verification, or by direct communication with officials of the appropriate board. Osteopathic board certification may be verified through the AOA Physician Database. Copies of documents used to verify certification are to be filed in the credentialing and privileging file.

3. Dentists. Board certification may be verified contacting the appropriate Dental Specialty Board.

4. Podiatrists. The following three specialties are currently recognized by the House of Delegates, American Podiatric Medical Association and VA: the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics, and the American Board of Podiatric Public Health.

5. Other Occupations. Board certification and other specialty certificates must be primary source verified by contacting the appropriate board or certifying organization.

6. Evidence of Continuing Certification. Board certification and other specialty certificates, which are time-limited or carry an expiration date, must be reviewed and documented prior to expiration.

Section 7. Licensure

1. Requirement for Full, Active, Current, and Unrestricted Licensure. Applicants being credentialed in preparation for applying for clinical privileges must possess at least one full, active, current, and unrestricted license that authorizes the licensee to practice in the state of licensure and outside VA without any change being needed in the status of the license.

2. Qualification Requirements of Title 38 United States Code (U.S.C.) Section 7402(f). Applicants being credentialed for a position identified in 38 U.S.C. Section 7402(b) (other than a Director) for whom State licensure, registration, or certification is required and who possess or have possessed more than one license (as applicable to the position) are subject to the following provisions:

- a. Applicants and individuals appointed on or after November 30, 1999, who have been licensed, registered, or certified (as applicable to such position) in more than one State and who had such license, registration, or certification revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for appointment, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status.
- b. Individuals who were appointed before November 30, 1999, who have maintained continuous appointment since that date and who are identified as having been licensed, registered, or certified (as applicable to such position) in more than one State and, on or after November 30, 1999, who have had such revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration, or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for continued employment in such position, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status.
- c. Where a license, registration, or certification (as applicable to the position) has been surrendered, confirmation must be obtained from the primary source that the individual was notified in writing of the potential for termination for professional misconduct, professional incompetence, or substandard care. If the entity does verify written notification was provided, the individual is not eligible for employment unless the surrendered credential is fully restored.
- d. Where the State licensing, registration, or certifying entity fully restores the revoked or surrendered credential, the eligibility of the provider for employment is restored. These individuals would be subject to the same employment process that applies to all individuals in the same job category who are entering the VA employment process. In addition to the credentialing requirements for the position, there must be a complete review of the facts and circumstances concerning the action taken against the State license, registration, or certification and the impact of the action on the professional conduct of the applicant. This review must be documented in the licensure section of the credentials file.

e. This policy applies to licensure, registration, or certification require, as applicable, to the position subsequent to the publication of this policy and required by statute or VA qualification standards, effective with the date the credential is required.

3. When a practitioner enters into an agreement (disciplinary or non-disciplinary) with a State licensing board to not practice the occupation in a State, the practitioner is required to notify VA of the agreement. VA must obtain information concerning the circumstances surrounding the agreement. This includes information from the primary source of the specific written notification provided to the practitioner, including, but not limited to: notice of the potential for termination of licensure for professional misconduct, professional incompetence, or substandard care. If the entity does verify written notification was provided, all associated documentation must be obtained and incorporated into the credentialing and privileging file and VetPro. The practitioner must be afforded an opportunity to explain in writing, the circumstances leading to the agreement. VA EKHCS officials must evaluate the primary source information and the individual's explanation of the specific circumstances, documenting this review in the credentialing and privileging file and VetPro.

4. There may be instances where actions have been taken against an applicant's license for a clinically-diagnosed illness. Those applicants are eligible for appointment where they are acknowledged by the licensing, registering, or certifying entity as stable, the licensure action did not involve substandard care, professional misconduct, or professional incompetence, and the license, certificate, or registration is fully restored. A thorough analysis of the information obtained from the entity must be documented, signed by the appropriate reviewers and approving officials, and filed in the licensure section of the Credentialing and Privileging Folder.

5. Exceptions to Licensure. As part of the credentialing process, the status of an applicant's licensure and that of any required or claimed certifications must be reviewed and primary source verified. Except as provided in VA Handbook 5005, Part II, Chapter 3, subparagraph 14b, all LIPs must have a full, active, current, and unrestricted license to practice in any State, Territory, or Commonwealth of the United States, or in the District of Columbia. The only exceptions provided in VA Handbook 5005 are:

a. An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a State license which is limited on the basis of non-citizenship or not meeting the residence requirements of the State.

b. An individual who has been granted an institutional license by the State which permits faculty appointment and full, unrestricted clinical practice at a specified educational institution and its affiliates, including VA EKHCS; or, an institutional license which permits full, unrestricted clinical practice at VA EKHCS. This exception is only used to appoint an individual who is a well-qualified, recognized expert in the individual's field, such as a visiting scholar, clinician, and/or research scientist, and only under authority of 38 U.S.C.

7405. It may not be used to appoint an individual whose institutional license is based on action taken by a SLB.

c. An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a time-limited or temporary State license or permit pending a meeting of the SLB to give final approval to the candidate's request for licensure. The license must be active, current, and permit a full, unrestricted practice. Appointments of health care professionals with such licenses must be made under the authority of 38 U.S.C. 7405 and are time-limited, not to exceed the expiration date of licensure.

d. A resident who holds a license which geographically limits the area in which practice is permitted or which limits a resident to practice only in specific health care facilities, but which authorizes the individual to independently exercise all the professional and therapeutic prerogatives of the occupation. In some States, such a license may be issued to residents in order to permit them to engage in outside professional employment during the period of residency training. The exception does not permit the employment of a resident who holds a license which is issued solely to allow the individual to participate in residency training.

6. SLBs may restrict the license of a practitioner for a variety of reasons. Among other restrictions, an SLB may suspend the licensee's ability to independently prescribe controlled substances or other drugs; selectively limit one's authority to prescribe a particular type or schedule of drugs; or accept one's offer or voluntary agreement to limit the authority to prescribe, or provide an "inactive" category of licensure.

7. Some states authorize a grace period after the licensure and/or registration expiration date, during which an individual is considered to be fully licensed and/or registered whether or not the individual has applied for renewal on a timely basis. VA EKHCS officials will not initiate separation procedures for failure to maintain licensure or registration on a practitioner whose only license and/or registration has expired if the State has such a grace period and considers the practitioner to be fully and currently licensed and/or registered.

8. Physician Applicants. Physician applicants including physician residents who function outside of the scope of their training program, i.e., who are appointed as Admitting Officer of the Day, must be screened with the FSMB prior to appointment.

The FSMB is a disciplinary information service and reports only those disciplinary actions resulting from formal actions taken by reporting medical licensing and disciplinary boards or similar official sources.

b. Appointment to the medical staff, and granting of clinical privileges is not complete until screening against the FSMB Disciplinary Files is documented in VetPro. It must be documented in VetPro that information obtained through screening against the FSMB Disciplinary Files is verified through the primary source and that this information has been

considered during the appointment process. If additional information is needed from the practitioner in response to this information, that must be obtained through, and documented in VetPro.

c. Those practitioners who were screened against the FSMB Disciplinary Files by VA Central Office in 2002, or subsequent to this date were screened through VetPro, are placed in VHA's FSMB Disciplinary Alerts Service. Practitioners entered into the VHA's FSMB Disciplinary Alerts Service are continuously monitored. Orders reported to the FSMB from licensing entities, as well as the Department of Health and Human Services (DHHS) OIG and the Department of Defense (DOD), initiate an electronic alert that an action has been reported to VHA's Credentialing and Privileging Program Director.

- (1) The registration of practitioners into this system is based on these queries and only on these queries.
- (2) This monitoring is on-going for registered practitioners.
- (3) Alerts received by VHA's Credentialing and Privileging Program Director must be forwarded to the appropriate VA facility for primary source verification and appropriate action.
- (4) Facility credentialing staff must obtain primary source information from the State licensing board for all actions related to the disciplinary alert. Complete documentation of this action, including the practitioner's statement is to be scanned into VetPro before filing in the paper credentials file. Medical staff leadership is to review all documentation to determine the impact on the practitioner's continued ability to practice within the scope of privileges granted. This review must be completed within 30 days of the notice to the facility staff of the alert and completely documented in VetPro prior to filing in the paper file.
- (5) Practitioner names must be removed from the VHA FSMB Disciplinary alerts Service when the practitioner file is inactivated in VetPro, or when the practitioner's appointment lapses in VetPro.

9. Appointment of Candidates with Previous or Current Adverse Action Involving Licensure. Physicians and dentists, or other licensed practitioners who have had a license or licenses restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, may be appointed under the appointment procedures that apply to other physicians, dentists, or other health professionals. Refer to Handbook 1100.19 for detailed information.

10. Verification with SLB(s).

Verification of the license:

a. Can be made through a letter or by telephone and documented on a report of contact. Electronic means of verification are also acceptable, as long as the site is maintained by the primary source and there is no disclaimer regarding authenticity. If verification of licensure is made by telephone or electronic means, a written request for verification must be made within 5 working days accompanied by VA Form 10-0459 signed by the practitioner requesting verification and disclosure of requested information concerning each:

- (1) Lawsuit, civil action, or other claim brought against the practitioner for malpractice or negligence;
- (2) Disciplinary action taken or under consideration, including any open or previously concluded investigations; and
- (3) Or any changes in the status of the license and all supporting documentation related to the information provided.

b. Must be completed in writing within 30 days of appointment and scanned into VetPro prior to being filed in the paper credentials file.

11. Filing

Verification of licensure and/or registration must be filed in Section IV of the Credentialing and Privileging folder and in the Licensure portion of VetPro.

Section 8. Drug Enforcement Agency (DEA) Certification

1. Where a practitioner's State of licensure requires individual DEA certification in order to be authorized to prescribe controlled substances, the practitioner may not be granted prescriptive authority for controlled substances without such individual DEA certification.
2. Physicians, dentists, ARNPs, PAs, CRNAs, PharmDs and certain other professional practitioners may apply for and be granted renewable certification by the Federal and/or State DEA, to prescribe controlled substances as part of their practice. Certification must be verified for individuals who claim on the application form to currently hold or to have previously held DEA certification. Individual certification by DEA is not required for VA practice, since practitioners may use the facility's institutional DEA certificate with a suffix.
3. Each applicant possessing a DEA certificate must document information about the current or most recent DEA certificate on the appropriate VA application form. Any applicant whose DEA certification (Federal and/or State) has ever been revoked, suspended, limited, restricted in any way, or voluntarily or involuntarily relinquished, or not renewed, is required to furnish a written explanation at the time of filing the application and at the time of reappraisal.

(a) A copy of the current Federal DEA certification must be physically seen prior to appointment and reappointment.

(b) Verification of a State DEA or Controlled Dangerous Substance (CDS) certificate can be made through a letter or by telephone and documented on a report of contact. Electronic means of verification are also acceptable as long as the site is maintained by the primary source and there is a disclaimer regarding authenticity.

Section 9. Employment Histories and Pre-employment References

For practitioners requesting clinical privileges, at least three references must be obtained including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges. Peer references are best obtained from those of the same discipline or profession who practice with, and know the practitioner's practice. If possible at least one of the peer references needs to be obtained from someone of the same discipline or profession who can speak with authority on the practitioner's clinical judgment, technical skill, etc.

1. For any candidate whose most recent employment has been private practice for whom employment histories may be difficult to obtain, VA facility officials must contact any institution(s) where clinical privileges are and/or were held, professional organizations, references listed on the application form, and/or other agencies, institutions or persons who would have reason to know the individual's professional qualifications.

a. All references must be documented in writing. Written records of telephone or personal contacts must include who was spoken to, that person's position and title, the date of the contact, a summary of the specific information provided, the name of the organization (if appropriate), and the reason why a telephone or personal contact was made in lieu of a written communication.

b. For applicants requesting clinical privileges, the facility needs to send a minimum of two requests to verify that the practitioner's currently held or most recently held clinical privileges are (or were) in good standing with no adverse actions or reductions for the specified period. For those health care professionals who have recently completed a training program, one reference needs to be from the Program Director attesting to the individual's competency and skill.

2. Ideally, references need to be from authoritative sources, which may require that facility officials obtain information from sources other than the references listed by the applicant. As appropriate to the occupation for which the applicant is being considered, references need to contain specific information about the individual's scope of practice and level of performance. For example, information on:

a. The number and types of procedures performed, range of cases managed, appropriateness of care offered, outcomes of care provided, etc.

- b. The applicant's medical and clinical knowledge, interpersonal skills, communication, clinical judgment, technical skills, and professionalism as reflected in results of quality improvement activities, peer review, and/or references, as appropriate.
- c. The applicant's health status in relation to proposed duties of the position and, if applicable, to clinical privileges being requested.

3. Employment information and references are filed in Section V of the Credentialing and Privileging folder and the appropriate portion of VetPro.

Section 10. Health Status

All applicants and employees are required to declare on the appropriate health status form that there are no physical or mental health conditions that would adversely affect one's ability to carry out requested responsibilities. This declaration of health must be confirmed by a physician and may not be related to the applicant by blood or marriage.

Section 11. Malpractice Considerations

1. Applicants. VA application forms, or supplemental forms, require applicants to give detailed written explanations of any involvement in administrative, professional, or judicial proceedings, including Federal tort claims proceedings, in which malpractice is, or was, alleged. If an applicant has been involved in such proceedings, a full evaluation of the circumstances must be made by officials participating in the credentialing, selection, and approval processes prior to making any recommendation or decision on the candidate's suitability for VA appointment.
2. Employees and Other Returning Practitioners. At the time of initial hire, a new appointment after a break in service, or reappraisal, each employee or returning practitioner (e.g. contractor) is asked to list any involvement in administrative, professional or judicial proceedings, including Tort claims, and to provide a written explanation of the circumstances, or change in status. A review of clinical privileges, as appropriate, must be initiated if clinical competence issues are involved.
3. Primary Source Information. Efforts should be made to obtain primary source information regarding the issues involved and the facts of the cases. The Credentialing and Privileging folder must contain an explanatory statement by the practitioner and evidence that the facility evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication by an insurance company, court of jurisdiction, or statement of claim status from the attorney. A good faith effort to obtain this information must be documented by a copy of the refusal letter or report of contact.

4. Evaluation of Circumstances. Facility evaluating officials will consider VA's obligation as a health care provider to exercise reasonable care in determining that health care professionals are properly qualified, recognizing that many allegations of malpractice are proven groundless.

a. Facility officials must evaluate the individual's explanation of specific circumstances in conjunction with the primary source information related to the payment in each case. The practitioner's explanatory statement is to be documented in the Supplemental Questions.

b. NPDB-HIPDB reports contain information regarding any malpractice payment made on behalf of the practitioner. This information is considered a secondary source and does not meet the standard of primary source verification. Primary source verification must be obtained on this information from the appropriate sources.

Section 12. NPDB – HIPDB Screening

1. Proper screening through the NPDB-HIPDB is required for applicants, including: physician residents who function outside of the scope of their training program, i.e., those appointed as Admitting Officer of the Day; all members of the medical staff and other health care professionals who hold clinical privileges, who are, or have ever been, licensed to practice their profession or occupation in any job title represented in the NPDB and HIPDB Guidebooks; or who are required to be credentialed in accordance with this policy. The NPDB-HIPDB is a secondary flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information received in response to an NPDB-HIPDB query is to be considered together with other relevant data in evaluating a practitioner's credentials; it is intended to augment, not replace, traditional forms of credentials review. NPDB-HIPDB screening is required prior to appointment, including reappointment and transfer from another VA facility, whether or not VA requires licensure for appointment, reappointment, or transfer.

a. 2. VetPro maintains evidence of query submission and response received, as well as any reports obtained in response to the query, and it meets the NPDB-HIPDB requirement.

3. Because the NPDB-HIPDB is a secondary information source, any reported information must be validated by appropriate VA officials with the primary source, i.e., SLB, health care Entity, malpractice payer to include, but not limited to the circumstances for payment (e.g., payment history in and of itself is not sufficient).

4. Screening applicants and appointees with the NPDB-HIPDB and enrollment in the NPDB-HIPDB PDS does not abrogate the COS's and appropriate service chief's responsibility for verifying all information prior to appointment, privileging and/or re-privileging, or proposed Human Resource Management action.

5. If the NPDB-HIPDB screen shows adverse action or malpractice reports, an evaluation of the circumstances and documentation thereof, is required. This evaluation needs to follow the

guidelines outlined in preceding subparagraph 5k(4) entitled “Evaluation of Circumstances,” for malpractice, and similarly for adverse actions.

6. Appointment and Termination of Employment under Title 5 and Title 38 Staff Relative to NPDB-HIPDB Screening:

- a. Clinically privileged and otherwise credentialed practitioners affected by this Handbook are to be appointed only after enrollment in the NPDB-HIPDB PDS has been initiated, including Temporary Appointment for Urgent Patient Care Needs and Expedited Appointments.
- b. If the NPDB-HIPDB screen through enrollment in the NPDB-HIPDB PDS shows action against clinical privileges, adverse action regarding professional society membership, medical malpractice payment for the benefit of the practitioner, or Federal health care program exclusion, facility officials must verify that the practitioner fully disclosed all related information required and requested by VA in its pre-employment, credentialing, and/or clinical privileging procedures.
- c. The practitioner may be employed or continued in employment only after applicable procedural requirements are met.
- d. Circumstances requiring review by the VISN CMO are:
 - (1) Three or more medical malpractice payments in payment history.
 - (2) A single medical malpractice payment of \$550,000 or more, or
 - (3) Two medical malpractice payments totaling \$1,000,000 or more
- e. The VISN CMO review must be documented on the Service Chief’s Approval screen in VetPro as an additional entry recommending appointment in these cases.
- f. Once requirements for consideration and evaluation of any action reported by NPDB-HIPDB have been completed, the appointment or continue appointment decision, if appropriate, must be made following guidance in this Handbook; Title 5 policies and procedures specified in Title 5 code of Federal Regulations (CFR) 315, 731, or 752; Federal or VA acquisition regulations; VA Directive and Handbook 0710; and VA Directive and Handbook 5021, as they apply to the category of practitioner.

Section 13. Credentialing and Privileging for Telehealth and Teleconsultation.

- 1. Credentialing for Telehealth and Teleconsultation. When the staff of a facility determines that telemedicine and/or teleconsultation is in the best interest of quality patient care, appropriate credentialing and privileging is required.

- a. All practitioners treating patients using telemedicine and teleconsultation must be qualified to deliver the required level of consultation, care, and treatment with the appropriate credentialing and privileging, regardless of the technology used, and they must be credentialed and privileged to deliver that care.
 - b. The practitioner providing the telemedicine and/or teleconsultation services must be credentialed and privileged in accordance with Handbook 1100.19.
2. Teleconsultation. The practitioner providing only teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located when providing teleconsultation services.
3. Telemedicine. When telemedicine services are being provided by the practitioner who directs, diagnoses, or otherwise provides clinical treatment (i.e., teleradiology, teledermatology, etc.) to a patient using a telemedicine link, the practitioner must be appointed, credentialed, and privileged at the facility which receives the telemedicine services (patient site), as well as at the site providing the services.
4. A separate delineation and granting of privileges must be made by the facility receiving the telemedicine services. Appropriate credentialing will be performed. Contracts for Telemedicine and/or Teleconsultation Services. Contracts for telemedicine and/or teleconsultation services need to require that these services be performed by appropriately-licensed individuals.
5. Temporary Medical Staff Appointments for Urgent Patient Care Needs. NOTE: *Temporary appointments are for emergent or urgent patient care only and NOT to be used for administrative convenience.*
 - a. Temporary medical staff appointments for urgent patient care needs requires appointment before full credentialing information has been received. Credentialing is a key component in any patient safety program, the appointment of providers with less than complete credentials packages warrants serious consideration and thorough review of the available information. The COS will approve all Temporary Appointments. Examples include:
 - (1) A situation where a physician becomes ill or takes a leave of absence and an LIP would need to cover the physician's practice until the physician returns.
 - (2) A situation where a specific LIP with specific skill is needed to augment the care to a patient that the patient's current privileged LIP does not possess.
 - c. When there is an emergent or urgent patient care need, a temporary appointment may be made, in accordance with VA Handbook 5005, Part II, by the facility Director prior to receipt of references or verification of other information and action by a Professional Standards Board. Minimum required evidence includes:

- (1) Verification of at least one, active, current, unrestricted license with no previous or pending actions;
 - (2) Confirmation of current comparable clinical privileges;
 - (3) Response from NPDB-HIPDB PDS registration with no match;
 - (4) Response from FSMB with no reports;
 - (5) Receipt of at least one peer reference who is knowledgeable of and confirms the provider's competence, and who has reason to know the individual's professional qualifications; and
 - (6) Documentation by the facility Director of the specific patient care situation that warranted such an appointment.
- d. In those cases where an application is completed prior to the Temporary Appointment for Urgent Patient Care needs, it must be a "clean" application with no current or previously successful challenges to licensure; no history of involuntary termination of medical staff membership at another organization; no voluntary limitation, reduction, denial, or loss of clinical privileges; and no final judgment adverse to the applicant in a professional liability action.
- e. Temporary appointments may not be renewed or repeated.
- f. An application through VetPro must be completed within 3 calendar days of the date the appointment is effective. This includes Supplemental Questions, a Declaration of Health, and a release of formation. This additional information facilitates the required completion of the practitioner credentialing for these practitioners used in urgent patient care needs situations, as well as providing additional information for evaluation of the current Temporary Appointment and reducing any potential risk to patients.
- g. If the Temporary appointment is not converted to another form of medical staff appointment, complete credentialing must be completed, even if completion occurs after the practitioner's temporary appointment is terminated or expires. At a minimum, the LIP must submit a VetPro application, and all credentials must be verified. If unfavorable information was discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

Section 14. Expedited Appointments to the Medical Staff.

1. There may be instances where expediting a medical staff appointment for licensed independent providers is in the best interest of quality patient care. This process may be incorporated into the appropriate VHA medical treatment facility Bylaws, policy, or procedures for expediting the medical staff appointment.

2. The credentialing process for the Expedited Appointment to the Medical Staff cannot begin until the licensed independent provider completes the credentials package, including but not limited to, a complete application; therefore, the provider must submit this information through VetPro and documentation of credentials must be retained in VetPro.
3. Credentialing requirements for this process must include confirmation of:
 - a. The physician's education and training (which, if necessary, can be accomplished in 24 hours through the purchase of the American Medical Associations' Physician 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;
 - c. Confirmation on the declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;
 - d. Query of licensure history through the FSMB Action Data Center with no report documented;
 - e. Confirmation from **two** peer references who are knowledgeable of and confirm the physician's competence, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges, or who would have reason to know the individual's professional qualifications;
 - f. Current comparable privileges held in another institution; and
 - g. NPDB-HIPDB query with documentation of no match.
4. 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 Medical Executive Board, consisting of at least two members of the full committee, may recommend appointment to the medical staff. Full credentialing must be completed within 60 calendar days and presented to the Medical Executive Board for ratification.
5. The expedited appointment process may only be used for what are considered "clean" applications. The expedited appointment process cannot be used:
 - a. If the application is not complete (including answers to Supplemental Questions, Declaration of health, and Bylaws Attestation); or
 - b. If there are current or previously successful challenges to licensure; or

- c. If there is any history of involuntary limitation, reduction, denial, or loss of clinical privileges;
 - d. If there has been a final judgment adverse to the applicant in a professional liability action.
6. This recommendation by the delegated subcommittee of the Medical Executive board must be acted upon by the VHA medical treatment facility Director. The 60 calendar days for the completion of the full credentialing process begins with the date of the Director's signature.
7. For those providers where there is evidence of a current or previously successful 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 Medical Executive Board.
8. This is a one-time appointment process for initial appointment to the medical staff and may not exceed 60 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 60 calendar days of the Expedited Appointment or the medical staff appointment is automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director, even though ratification of the appointment is accomplished within 60 calendar days (the effective date does not change).
9. Temporary appointments for Urgent Patient Care Needs-provisions exist in VHA Handbook 1100.19 for this type of appointment.

Section 15. Reappraisal

1. Reappraisal is the process of evaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the facility. The reappraisal process must include: the practitioner's statements regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction or loss of privileges at another hospital; loss of medical staff membership; pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment; mental and physical status; and any other reasonable indicators of continuing qualification and competency; additional information regarding current and/or changes in licensure and/or registration status (primary source verification is required at the time of expiration of the license and at the time of reappointment); NPDB-HIPDB PDS registration and report results; peer recommendations; continuing medical education and continuing education units; and verification regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review.
2. Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and informing the Service Line of

any changes in the status of these credentials at the earliest date after notification is received by the individual. At the time of expiration of any license, and at the time of reappraisal, prior to reappointment, the practitioner must provide a signed release of information VA Form 10-0459 which authorizes the primary source to provide VA with written verification of requested information and to disclose information concerning each lawsuit, civil action, or other claim brought against the practitioner for malpractice or negligence; each disciplinary action taken or under consideration; any open or previously concluded investigations; any changes in the status of the license; and all supporting documentation related to the information provided.

3. Providers must be cognizant of the time it takes to complete the written verification of licensure at the time of expiration and reappraisal. Providers must ensure that they submit all necessary information timely in order to complete verification prior to expiration of license or reappointment or practitioner will not be allowed to practice.

ARTICLE V. PRIVILEGING

Section 1. Provisions

1. Privileges must be facility specific. This means that privileges can only be granted within the scope of the medical facility mission. Only privileges for procedures actually provided by the VA facility may be granted to a practitioner.

2. Only practitioners who are licensed and permitted by law and the facility to practice independently may be granted clinical privileges. Midlevel providers are permitted to provide services under a scope of practice as permitted by state licensure and law, and as approved by facility Director.

3. Clinical privileging is the process by which the institution grants the practitioner permission to independently provide specified medical or other patient care services, within the scope of the practitioner's license and/or an individual's clinical competence as determined by peer references, professional experience, health status (as it relates to the individual's ability to perform the requested clinical privileges), education, training, and licensure and registration.

Section 2. Review of Clinical Privileges.

Applicants completing application forms are required to respond to questions concerning clinical privileges at VA and non-VA facilities. A minimum of two efforts to obtain verification of clinical privileges currently, or most recently, held at other institutions is to be made and documented in writing in the Credentialing and Privileging folder. That verification needs to indicate whether the privileges are (or were) in good standing with no adverse actions or reductions for the specified period of time. If the verification indicates that there are pending, or were previous, adverse actions or reductions for the specified period of time, the particulars of the action or reduction must be obtained and documentation of a thorough review by officials involved in the appointment process must be included with credentialing information.

Section 3. Procedures.

1. Privileges are granted according to the procedures delineated within Handbook 1100.19. Clinical privileges are granted for a period not to exceed 2 years, however clinical privileges for contracts may not extend beyond the contract period. Clinical privileges are not to be extended beyond the 2-year period, which begins from the date the privileges are signed, dated, and approved by the facility Director

a. General Criteria.

(1) General criteria for privileging must be uniformly applied to all applicants.

- Verification that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
 - a. a current picture hospital ID card
 - b. a valid picture ID issued by a state or federal agency (e.g., driver's license or passport).
- Current licensure and/or certification, as appropriate, verified with the primary source
- The applicant's specific relevant training, verified with the primary source
- The applicants current competence
- Evidence of physical ability to perform and requested privileges
- Data from the professional practice review by an organization that currently privileges the applicant (if available)
- Peer and/or faculty recommendation
- Review of practitioner's performance within the hospital
- A statement that no health problems exist that could affect his or her ability to perform the privileges requested.
- National Practitioner Data Bank is queried.
- Peer recommendations include:
 - a. Medical/clinical knowledge
 - b. Technical and clinical skills
 - c. Clinical judgment
 - d. Interpersonal skills
 - e. Communication skills
 - f. Professionalism
- Before recommending privileges, the folder is evaluated on:
 - a. Challenges to any licensure or registration
 - b. Voluntary and involuntary relinquishment of any license or registration
 - c. Voluntary and involuntary termination of medical staff membership
 - d. Voluntary and involuntary limitations, reduction, or loss of clinical privileges

- e. Any evidence of an unusual pattern or an excessive number of professional liability actions
- f. Documentation of the applicant's health status
- g. Relevant practitioner-specific data as compared to aggregate data, when available
- h. Morbidity and mortality data, when available the Professional Standards Board reviews the credentialing data and determines if there is sufficient information to grant, limit or deny the requested privileges.
- Each practitioners scope of privileges is updated as changes in clinical privileges are made.
- Providers are notified regarding the privileges granted, denied and/or any conditions.

(2) Each service chief must establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility. Clinical privileges must be based on evidence of an individual's current competence. When privilege delineation is based primarily on experience, the individual's credentials record must reflect that experience, and the documentation must include the numbers, types, and outcomes of related cases.

b. Delineation of Privileges. Delineated clinical privileges are an accurate, detailed, and specific description of the scope and content of patient care services for which a practitioner is qualified; they are based on credentials and performance and authorized by the facility.

(1) The criteria for the delineation of privileges are determined by the individual services, recommended by the Medical Executive Board as defined in the Medical Staff Bylaws, and approved by the facility Director. These criteria and delineated privileges are to be reviewed on a regular basis as defined in the Medical Staff Bylaws.

c. Service Specific Privileges. Each practitioner must be assigned to, and have clinical privileges in, one clinical service and may be granted privileges in other clinical services. The exercise of clinical privileges within any service is subject to the policies and procedures of that service and the authority of that service chief.

d. Setting Specific Privileges. Privileges are setting specific.

Section 4. Initial Privileges.

1. Clinical privileges must be granted for all physicians, dentists, and other health care professionals licensed for independent practice, covered by this Handbook when they are involved in patient care. The intent of this process is to ensure that all physicians, dentists, and other health care practitioners, when they are functioning independently in the provision of medical care, have privileges that define the scope of their actions, which is based on current competence within the scope of the mission of the facility, and other relevant criteria. Documentation of clinical activity (i.e., evidence that a practitioner has performed a procedure) is one component of the competency equation. The second component is whether or not the

practitioner has had good outcomes in practice or when performing a procedure. The process for the requesting and granting of clinical privileges follows:

- a. Clinical privilege requests must be initiated by the practitioner. For all practitioners desiring clinical privileges, the initial application for appointment must be accompanied by a separate request for the specific clinical privileges desired by the applicant. The applicant has the responsibility to establish possession of the appropriate qualifications, and the clinical competency to justify the clinical privileges request.
- b. The applicant's request for clinical privileges, as well as all credentials offered to support the requested privileges, must be provided for review to the service chief responsible for that particular specialty area. The service chief must review all credentialing information including health status (as it relates to the ability to perform the requested clinical privileges), experience, training, clinical competence, judgment, clinical and technical skills, professional references, conclusions from performance improvement activities that are not protected under 38 U.S.C. 5705. The service chief must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending individual privileges and personally complete the "Service Chief's Approval" in VetPro. Upon completion of this assessment, the service chief makes a recommendation as to the practitioner's request for clinical privileges. The service chief recommends approval, disapproval, or a modification of the requested clinical privileges. This recommendation may include a limited period of direct supervision, or proctoring, by an appropriately-privileged practitioner for privileges when a practitioner has had a lapse in clinical activity, or for those procedures that are high risk as defined by medical center policy.
- c. Subsequent to the service chief's review and recommendation, the request for privileges, along with the appointment recommendation of the Professional Standards Board (PSB) must be submitted to the Medical Executive Board for review. The Medical Executive Board evaluates the applicant's credentials to determine if clinical competence is adequately demonstrated to support the granting of the requested privileges. Minutes must reflect the documents reviewed and the rationale for the stated conclusion. A final recommendation is then submitted to the facility Director.
- d. Residents who are appointed, outside of their training program, to work on a fee basis as Admitting Officer of the Day must be licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program, and must meet the same requirements as all physicians and dentists appointed at the facility. The term "resident" includes health care professionals in advanced PG education programs who are typically referred to as "fellows."
- e. Copies of current clinical privileges are available to hospital staff in order to ensure providers are functioning within the scope of their clinical privileges. Operating rooms and intensive care units are examples of areas where staff must be aware of provider privileges.

Copies of privileges may be given to individuals on a need-to-know basis (e.g., a service chief responsible for monitoring compliance with the privileges granted, or a pharmacist who verifies prescribing privileges or established limitations on prescribing for certain medical staff members). The mechanism is to be concurrent with the exercise of privileges, not retrospective.

f. The requesting and granting of clinical privileges for COSs must follow the procedures, as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant service chief responsible for the particular specialty area in which the COS or Director requests privileges. When considering clinical privileges for the COS an appropriate practitioner must chair the Medical Executive Board and the COS must be absent from the deliberations. The Medical Executive Board recommendation regarding approval of requested privileges is submitted directly to the facility Director for action.

g. The privileging of facility COS desiring clinical privileges must follow the procedures as outlined for new practitioners. The approval authority for the requested privileges is to be delegated to the Associate Director.

h. A denial of initial privileges, for whatever reason, is not reportable to the NPDB. Where it is determined, for whatever reason that the initial application and request for clinical privileges should be denied, the credentialing file, and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the facility Director. A “Do No Appoint” screen must be completed in VetPro documenting the date of the decision.

Section 5. Temporary Privileges for Urgent Patient Care Needs.

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

Section 6. Disaster Privileges.

1. Disaster privileges may be granted when the facility has activated the emergency management plan and the facility is unable to handle the immediate patient needs. Granting disaster privileges must include:

- a. Disaster privileges will be granted by the MOD or highest ranking physician on duty at the time and that individual will discuss the need with the Incident Commander. (See Environment of care Guide; Emergency Management).
- b. The Physician granting disaster privileges will ensure that the individual has appropriate identification to practice in the capacity offered.
- c. The licensed independent providers who are granted disaster privileges will be issued a badge by the Incident Commander and will be assigned to be supervised by a staff physician during the disaster.
- d. Verification process at the time disaster privileges are granted will include:
 - (1) A current hospital photo identification card and evidence of current license to practice; or
 - (2) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); or
 - (3) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a Federal, state, or municipal entity.
 - (4) Health care professionals granted disaster privileges may practice on these disaster privileges for a period not to exceed 10 calendar days or the length of the declared disaster, whichever is shorter. At the end of this period, the practitioner needs to be converted to Temporary Privileges defined by this policy, or relieved.

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

Section 7. Focused Professional Practice Evaluation.

- 1. This is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility.
- 2. This is a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance.
- 3. Consideration for the focused professional practice evaluation is to occur at the time of initial appointment to the medical staff, or the granting of new, additional privileges., The focused

professional practice evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

4. The criteria for the focused professional practice evaluation plan are to be defined in advance, using objective criteria and time frames for monitoring by the Service Line Manager. The Service Line manager will recommend the FPPE Plan to the PSB/MEB. The PSB/MEB will recommend approval of the plan to the Director who will approve the plan. The Service Line Manager will share the plan with the provider who will accept the plan. This process may include any of the following monitoring techniques that are appropriate to the plan; periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.

5. Failure of a practitioner to accept the criteria for the focused professional practice evaluation will result in new privileges not being granted or additional actions taken as appropriate, for currently privileged providers.

6. Results of the Focused Professional Practice Evaluation must be documented in the practitioner's provider profile and reported to the Medical Executive Board for consideration in making the recommendation on privileges and other considerations.

Section 8. On-Going Monitoring of Privileges.

1. This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the medical staff leadership.

2. The VHA has a robust quality management and performance improvement process. The information collected analysis of patient care activities under this process is protected by 38 U.S.C. 5705 and may not be used during any portion of the review process for the granting of clinical privileges. The 38 U.S.C. 5705-protected materials may trigger the need to perform a more in-depth review of a practitioner. The criteria that would trigger a more in-depth review must be defined in advance, and be objective, measurable, and uniformly applied to all practitioners with similar privileges.

3. With very few exceptions, VHA data standing alone is not protected by 38 U.S.C. 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. Data that is not previously identified as protected by 38 U.S.C. 5705 and is collected as provider-specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program.

Section 9. Reappraisal and Re-privileging

1. Reappraisal. Reappraisal is the process of reevaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the facility.

a. Reappraisal for the granting of clinical privileges must be conducted for each practitioner at least every 2 years. However, reappraisal may be required more frequently for contractors, depending upon the length of the contract period and may not exceed the contract period.

(1) The reappraisal process must include:

(a) The practitioner's statements regarding successful or pending challenges to any licensure or registration;

(b) Voluntary or involuntary relinquishment of licensure or registration;

(c) Limitation, reduction or loss (voluntary or involuntary) of privileges at another hospital;

(d) Loss of medical staff membership;

(e) Pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment;

(f) Mental and physical status (as it relates to the ability to perform the requested clinical privileges); and

(g) Any other reasonable indicators of continuing qualifications.

b. The Credentialing and Privileging folder must contain an explanatory statement by the practitioner and evidence that the facility evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication from the primary source to include, but not limited to: an insurance company, court of jurisdiction, or statement of claim status from the attorney. In the case of the Federal Tort Claims Act (FTCA), information on the adjudication of the case may come from the facility Risk Manager, the Regional counsel, or the Office of medical-Legal Affairs.

c. If there is evidence of voluntary or involuntary relinquishment of licensure or registration (as applicable to the position), evidence must be obtained that the practitioner meets VA's licensure requirements.

- d. Additional information regarding licensure and/or registration status, NPDB-HIPDB PDS report results, peer recommendations, continuing medical education and continuing education unit accomplishments, and information regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review.
- e. Peer references are best obtained from those of the same discipline or profession who practice with, and know the practitioner's practice. If possible at least one of the peer references needs to be obtained from someone of the same discipline or profession who can speak with authority on the practitioner's clinical judgment, technical skill, etc.
- f. Where there is no one of the same discipline or profession with knowledge of the practitioner's practice, at least one peer reference must be obtained from a health care professional with essentially equal qualifications and comparable privileges with knowledge of the practitioner's performance and practice patterns. A second peer reference can be obtained from a health care professional who has a referral relationship with the practitioner.
- g. In instances where at least one peer reference cannot be obtained from a peer of the same profession or a professional with comparable privileges, assistance for the peer reference needs to be sought from the VISN CMO or VHA Program Director for the profession.
- h. Evaluation of professional performance, judgment, and clinical and/or technical competence and skills is to be based in part on results of provider-specific performance improvement activities. Ongoing reviews conducted by service chiefs must be comprised of activities with defined criteria that emphasize the facility's performance improvement plan, appropriateness of care, patient safety, and desired outcomes, and are not protected by 38 U.S.C. 5705. The individual providers' profiles may include provider-specific, non-38 U.S.C. 5705-protected data when applicable. For example, the provider-specific data may include the following information: information from surgical case or invasive procedure review; infection control reviews; drug usage evaluation; medical record review; blood usage review; pharmacy and therapeutic review; and monitoring and evaluation of quality, utilization, risk, and appropriateness of care. The relevant provider specific data in these provider profiles can be compared to de-identified aggregate data (like the blood use evaluation summary) as long as the implicit and explicit identification of other providers cannot occur. De-identified aggregate data needs to include providers with comparable or similar privileges.
- i. The reappraisal process needs to include consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in a practitioner's clinical practice. Relevant practitioner-specific data needs to be compared to the aggregate data of those privileged practitioners that hold the same or comparable privileges.

2. Re-privileging. Re-privileging is the process of granting privileges to a practitioner who currently holds privileges within the facility.

a. This process must be conducted at least every 2 years. However, clinical privileges granted to contractors may not extend beyond the contract period. Each new contract period requires reappraisal and re-privileging. Requests for privileges must be processed in the same manner as initial privileges. Practitioners must request privileges in a timely manner prior to the expiration date of current privileges.

b. The service chief must assess a minimum of two peer recommendations and all other information that addresses the professional performance, judgment, clinical and/or technical skills, any disciplinary actions, challenges to licensure, loss of medical staff membership, changes in clinical privileges at another hospital, health status (as it relates to the ability to perform the requested clinical privileges), and involvement in any malpractice actions. The service chief must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending individual privileges and complete the "Service Chief's Approval" in VetPro. Upon completions of this assessment, the service chief makes a recommendation as to the practitioner's request for clinical privileges.

c. The requested privileges and the service chief's recommendation must be presented, with the supporting credentialing, health status, and clinical competence information, to the PSB for review and recommendation. The decision of the Medical Executive Board must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and submitted to the facility Director, as the approving authority, for final action. Because facility mission and clinical techniques change over time, it is normal that clinical privileges may also change. The service chief must review, with the practitioner, the specific procedures and/or treatments that are being requested. Issues, such as documented changes in the facility mission, failure to perform operations and/or procedures in sufficient number, or frequency to maintain clinical competence in accordance with facility established criteria, or failure to use privileges previously granted, will affect the service chief's recommendation for the granting of new privileges, or the granting of the continuation of privileges. These actions must be considered changes and are not to be construed as a reduction, restriction, loss, or revocation of clinical privileges. Such changes must be discussed between the service chief and the involved practitioner.

(a) Practitioners may submit a request for modification of clinical privileges at any time. Requests to increase privileges must be accompanied by the appropriate documentation which supports the practitioner's assertion of competence, i.e., advanced educational or clinical practice program, clinical practice information from other institution(s), references, etc. The request must be made through VetPro by opening the electronic record for re-credentialing. In addition to verifying all current credentials and competency associated with this request, active licenses must be verified and a verification of the NPDB-HIPDB PDS

reports must be made. Requests for other changes need to be accompanied by an explanatory statement(s). The request for modification of clinical privileges, supporting documents, and practitioner's Credentialing and Privileging folder must be presented to the appropriate service chief for review. The service chief considers the additional information and the entire Credentialing and Privileging folder before making a recommendation to the Medical Executive Board. The Medical Executive Board then presents a recommendation to the facility Director for action. The process of reappraisal and granting new clinical privileges for facility Directors and COS's is the same as outlined in preceding paragraphs. The facility Director's or COS's request for privileges must be reviewed, and a recommendation made by the relevant service chief responsible for the particular specialty area in which the privileges are requested. When the COS is being considered for privileging, the COS must be absent from the Medical Executive Board deliberations, which an appropriate practitioner chairs. The Medical Executive Board recommendations related to the approval of the requested privileges must be submitted directly to the Director for action, or to the Associate Director who is authorized to act as facility Director for this purpose.

3. Denial and Non-renewal of Privileges. The paragraph defines policy and procedures related to the denial or non-renewal of clinical privileges and the requirements for reporting or not reporting such denials to the NPDB.

- a. At the time of initial application and request for clinical privileges, if it is determined for whatever reason that the application should be denied, the credentialing file and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the facility Director. A "Do Not Appoint" screen must be completed in VetPro documenting the date of this decision. This denial is not reportable to the NPDB.
- b. At the time of reappraisal and renewal of clinical privileges, privileges that are denied or not renewed based on facility resources must be documented as such in the Credentialing and Privileging file, as well as the appropriate minutes. This action is not reportable to the NPDB.
- c. For all other actions in which clinical privileges requested by a practitioner are denied or not renewed, the reason for denial must be documented. If the reason for denial or non-renewal is based on, and considered to be related to, professional incompetence, professional misconduct, or substandard care, the action must be documented as such and is reportable to the NPDB after appropriate internal VA Medical Center due process procedures for reduction and revocation of privileges, pursuant to this Handbook, are provided (see VHA Handbook 1100.17).

4. Reduction and Revocation of Privileges. This paragraph defines policy and procedures related to the reduction and/or revocation of clinical privileges based on deficiencies in professional performance.

a. Management officials are prohibited from taking or recommending personnel actions(resignation, retirement, reassignment, etc.) in return for an agreement not to initiate procedures to reduce or revoke clinical privileges where such action is indicated. In addition, reporting to the NPDB (including the submission of copies to SLBs) may not be the subject of negotiation in any settlement agreement, employee action, legal proceedings, or any other negotiated settlement. Such agreements or negotiations are not binding on VA and may form the basis for administrative and/or disciplinary action against the officials entering into such agreement or negotiated settlement.

b. A reduction or revocation of privileges may not be used as a substitute for disciplinary or adverse personnel action. Where a disciplinary or adverse personnel action is warranted, the action against the privileges is to be incorporated into the due process procedures provided for the disciplinary or adverse personnel action.

Any situation that results in a practitioner being proctored, where the proctor is assigned to do more than just observe, but rather exercise control or impart knowledge, skill, or attitudes to another practitioner ensuring that patient care is delivered in an appropriate, timely, and effective manner may constitute supervision. If this occurs after initial privileges have been granted, it is considered a restriction on the practitioner's privileges and, as such, is a reduction of privileges and is reportable to the NPDB if proctorship lasts longer than 30 days from the date the privileges are reduced or placed in a proctored status.

ARTICLE VI. FAIR HEARING AND APPELLATE REVIEW

Section 1. General Provisions

1. These activities may be separate from the Reappraisal and Re-privileging process. Data gathered in conjunction with the facility's performance improvement activity is an important tool for identifying potential deficiencies. Material that is obtained as part of a protected-performance improvement program (i.e., under 38 U.S.C. 5705), may not be used during the appraisal process, nor may any reduction or revocation of privileges action be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and must be rediscovered through the administrative review or investigation process.

2. Reduction and Revocation of Privileges. A reduction of privileges may include restricting or prohibiting performance of selected specific procedures, including prescribing and/or dispensing

controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically-disabling condition or further training in a particular area. Revocation of privileges refers to the permanent loss of clinical privileges.

3. If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures indicated in Handbook 1100.17 must be followed. Procedures for reduction and revocation of clinical privileges are identified in the following paragraphs, and apply to all practitioners included within the scope of this Handbook.

4. A practitioner who surrenders clinical privileges, resigns, retires, etc., during an investigation relating to possible professional incompetence or improper professional conduct must be reported to the NPDB in accordance with VA regulations 38 CFR Part 46 and VHA Handbook 1100.17. This includes the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct.

5. Adverse Professional Review Action. Any professional review action that adversely affects the clinical privileges of a practitioner for a period longer than 30 days, including the surrender of clinical privileges or any voluntary restriction of such privileges, while the practitioner is under investigation, is reportable to the NPDB pursuant to the provisions of the VHA policy regarding NPDB reporting.

Section 2. Summary Suspension.

Clinical privileges may be summarily suspended when the failure to take such an action may result in an imminent danger to the health of any individual. The notice of summary suspension needs to contain a notice to the individual of all due process rights.

1. When privileges are summarily suspended, the comprehensive review of the reason for summary suspension must be accomplished within 30 calendar days of the suspension with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to the facility Director for consideration and action. The Director must make a decision within 5 working days of receipt of the recommendations. This decision could be to exonerate the practitioner and return privileges to an active status, or that there is sufficient evidence of improper professional conduct or incompetence to warrant proceeding with a reduction or revocation process.

2. If the practitioner's clinical privileges are pending renewal and due to expire during a summary suspension or due process procedures for reduction or revocation, the clinical privileges must be denied pending outcome of the review and due process procedures. This denial is considered administrative until such time as a final decision is made in the summary suspension or due process procedures. This final decision determines whether an adverse action has occurred and the responsibility for reporting of the action. If the final action results in what

would have been a reportable event, it must be reported in accordance with VHA handbook 1100.17.

Section 3. Independent Contractors and/or Subcontractors

1. Independent contractors and/or subcontractors acting on behalf of VA are subject to the provisions of VA policies on credentialing and privileging and NPDB reporting. In the following circumstances, VA must provide the contractor and/or subcontractor with appropriate internal VA Medical Center due process, pursuant to the provisions of VHA Credentialing and Privileging policy regarding reduction and revocation of privileges, prior to reporting the contractor and/or subcontractor to the NPDB, and filing a copy of the report with the SLB(s) in the state(s) in which the contractor and/or subcontractor is licensed and in which the facility is located.:

- a. Where VA terminates a contract for possible incompetence or improper professional conduct, thereby automatically revoking the medical staff appointment and associated clinical privileges of the contractor and/or subcontractor;
- b. Where the contractor and/or subcontractor terminates the contract or subcontract, thereby surrendering medical staff appointment and associated privileges, either while under investigation relating to possible incompetence or improper professional conduct; and
- c. Where VA terminates the services (and associated medical staff appointment and clinical privileges) of a subcontractor under a continuing contract for possible incompetence or improper professional conduct.

Where a contract naturally expires, both the medical staff appointment and associated clinical privileges of the contractor and/or subcontractor are automatically terminated. This is not reportable to the NPDB.

3. Where a contract is renewed or the period of performance extended, the contractor and/or subcontractor must be credentialed and privileged similar to the initial credentialing process, with the exception that non-time limited information, e.g. education and training, does not need to be reverified.

Section 4. Automatic Suspension of Privileges.

Privileges may be automatically suspended for administrative reasons which may occur in instances where the provider is behind in dictation, or allowed a license to lapse and therefore does not have an active, current, unrestricted license.

1. Such instances must be weighed against the potential for substandard care, professional misconduct, or professional incompetence. A thorough review of the circumstances must be

documented with a determination of whether the cause for the automatic suspension does or does not meet the test of substandard care, professional misconduct, or professional incompetence.

2. Under no circumstances should there be more than three automatic suspensions of privileges in 1 calendar year, and no more than 20 days per calendar year. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in a calendar year, a thorough assessment of the need for the practitioner's services needs to be performed and documented and appropriate action taken. Any action is to be reviewed against all reporting requirements.

3. **Procedures Applicable to Administrative Heads.** Procedures to reduce and revoke clinical privileges identified within this Handbook are applicable to Directors, COSs, CMOs, and VISN Directors. All responsibilities normally assumed by the COS during the clinical privileging reduction or revocation process must be assigned to an appropriate practitioner who serves as acting chair of the Medical Executive Board. The COS may appeal the director's decision, or the Director may appeal the Associate Director's decision, regarding the reduction of privileges decision to the VISN Director, just as all practitioners may appeal such a decision. A VISN Director whose clinical privileges to practice at a given facility are reduced or revoked may appeal to the Chief VISN Officer.

Section 5. Reduction of Privileges

1. Initially, the practitioner receives a written notice of the proposed changes in privileges from the COS, which notice must include a discussion of the reason(s) for the change. The notice also needs to indicate that if a reduction or revocation is effected based on the outcome of the proceedings, a report must be filed with the NPDB, with a copy to the appropriate SLBs in all states in which the practitioner holds a license, and in the State in which the facility is located. The notice must include a statement of the practitioner's choice throughout the proceedings.

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

3. All information is forwarded to the facility Director for decision. The facility Director must make, and document, a decision on the basis of the record. If the practitioner disagrees with the facility Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 workdays after receipt of decision.

4. The facility Director must appoint a review panel of three professionals, within 5 workdays after receipt of the practitioner's request for hearing, to conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is

required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges; any other review processes must be conducted on the basis of the record.

- a. The practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.
- b. During such hearing, the practitioner has the right to:
 - (1) Be present throughout the evidentiary proceedings.
 - (2) Be represented by an attorney or other representative of the practitioner's choice.
 - (3) Cross-examine witnesses.
- c. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.
- d. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.
- e. The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.
- f. The facility Director must issue a written decision within 10 workdays of the date of receipt of the panel's report. If the practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.
- g. If the practitioner wishes to appeal the Director's decision, the practitioner may appeal to the appropriate VISN Director within 5 workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.
- h. The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the practitioner's appeal.

Section 6. Revocation of Privileges

1. Recommendations to revoke a practitioner's privileges must be made by the Medical Executive Board, based upon review and deliberation of clinical performance and professional conduct information.
 - a. A revocation of privileges requires removal from both employment appointment and appointment to the medical staff, unless there is a basis to reassign the practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. An example could be the revocation of a surgeon's privileges for clinical practice issues, when reassignment to a non-surgical area is beneficial to meeting other needs of the facility.
 - b. When revocation of privileges is proposed and combined with a proposed demotion or dismissal, the due process rights of the practitioner must be accommodated by the hearing provided under the dismissal process. Where removal is proposed, the due process procedures for removal and revocation of privileges must be combined. Dismissal constitutes a revocation of privileges, whether or not there was a separate and distinct privileging action, and must be reported without further review or due process to the NPDB.
 - c. When revocation of privileges is proposed and not combined with a proposed demotion or dismissal, the due process procedures under reduction of privileges must pertain.
2. In instances where revocation of privileges is proposed for permanent employees appointed under 38 U.S.C. 7401(1), the revocation proceedings must be combined with proposed action to discharge the employee under 38 U.S.C., Part V, Chapter 74, Subchapter V, or in accordance with current VA statutes, regulations, and policy.
3. For probationary employees appointed under 38 U.S.C. 7401(1), the proposed revocation requires probationary separation procedures contained in VA Handbook 5021. For employees appointed under 38 U.S.C. 7405, the proposed revocation requires actions to separate the employee under the provisions of VA Handbook 5021. Where proposed revocation is based on substandard care, professional misconduct, or professional incompetence, the probationary or temporary employee must be provided with the due process procedures that are provided for reduction of privileges, in addition to the procedures contained in VA Handbook 5021 for separation (i.e., the probationary procedures do not afford sufficient due process). When the proposed revocation is based on other grounds, the proposed revocation must be combined with the applicable separation procedures contained in VA Handbook 5021. Practitioners whose privileges are revoked based on substandard care, professional incompetence, or professional misconduct must be reported to the NPDB according to procedures identified in the VHA policy regarding NPDB reporting. When the revocation of privileges is proposed, consideration must be given to discharging or removing the practitioner, as applicable. It may be desirable to consider other alternatives, such as demotion or reassignment to a position that does not require privileges, where appropriate.

Section 7. Management Authority

Nothing in these procedures restricts the authority of management to temporarily detail or reassign a practitioner to non-patient care areas or activities, thus in effect suspending privileges while the proposed reduction of privileges or discharge, separation, or termination is pending.

1. The facility Director, acting in the position of Governing Body as defined in the Medical Staff Bylaws, is the final authority for all privileging decisions. This decision must be based on the recommendations of the appropriate Service Chief(s), COS, and/or Medical Executive Board.
2. Furthermore, the facility Director, on the recommendation of the COS, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns.
3. Nothing precludes VA from terminating a practitioner in accordance with VA Handbook 5021 procedures when the separation is not for a professional reason. Health care professionals appointed under authority of 38 U.S.C. 7405 may be terminated in accordance with VA Directive and Handbook 5021, when this is determined to be in the best interests of VA.

Section 8. Inactivation of Privileges

The inactivation of privileges occurs when a practitioner is not being an active member of the medical staff. It is difficult to quantify “extended period of time,” but facilities need to consider periods of no clinical practice or continued medical knowledge skills and learning, or when there is no formal clinical relationship between the facility and the practitioner as an extended period of time. Conditions that would be considered reasons for inactivation of privileges may include extended sick leave, and sabbatical with or without clinical practice while on sabbatical. When providers return to the medical center following these circumstances, credentialing and privileging activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be re-verified. Inactivation of privileges may not be used as a substitute for termination of medical staff appointment and/or revocation of privileges where such action(s) is warranted.

Section 9. Deployment and/or Activation Privilege Status

In those instances where a provider is called to active duty, the provider’s privileges are to be placed in a Deployment and/or Activation Status. The credential files continue to remain active with the privileges in this new status. If at all possible, this process for returning privileges to an active status must be communicated to providers before deployment.

1. Providers returning from active duty must be asked to communicate with the medical center staff as soon as possible upon returning to the area. **NOTE:** *This will hopefully occur with as much lead-time as possible.*

2. The provider must update the electronic Credentials File after the file has been reopened for credentialing updating licensure information, health status, and professional activities while on active duty.
3. The credentials file must be brought to a verified status. If the provider performed clinical work while on active duty, an attempt must be made to confirm the type of duties, the provider's physical and mental ability to perform these duties, and the quality of the work; this information must be documented.
4. The verified credentials, the practitioner's request for returning the privileges to an active status, and the service chief's recommendation are to be presented to the Medical Executive Board for review and recommendation. The decision of the Medical Executive Board must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and forwarded to the Director for recommendation and approval of restoring the provider's privileges to Current and Active Status from Deployment and/or Activation Status
5. In those instances when the practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.
6. In those instances where the privileges lapsed during the call to active duty, the provider needs to provide additional references for verification and the medical center staff needs to perform all verifications required for reappointment.
7. In those instances where the provider was not providing clinical care while on active duty, the provider in cooperation with the Service, Chief, Clinical Executive Board, and/or the Medical Executive Board must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges needs to be initiated, on a short-term basis.
8. If the file cannot be brought to a verified status and the practitioner's privileges restored by the Director, the practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VetPro:
 - a. Verification of all licenses that were current at the time of deployment and/or activation as current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.
 - b. Registration with the NPDB-HIPDB PDS with no match.
 - c. A response from the FSMB with no match.

- d. Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.
- e. Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

Section 10. Documentation of the Medical Staff Appointment and Clinical Privileges

1. Upon completion of the verification of credentials, recommendations by the appropriate service chief and committee(s), and approval by the Director (acting as the Governing Body), the documentation of the appointment and granting of clinical privileges can be completed. Medical staff appointments and the granting of clinical privileges are to be entered in VetPro and the period may not exceed 2 years. There is no provision for any extension of appointments or privileges.
2. The appointment can be effective as of the date signed by the Director, but may not become effective at a date later than 30 calendar days from the date signed by the Director or 45 calendar days after the recommendation of the Medical Executive Board, whichever is shorter.
3. The type of employment appointment, i.e., full-time, part-time, WOC, consultant, contract, fee basis, sharing agreement, or other needs be specified, the dates of the appointment, Service and/or Product Line, the Medical Center Director, the signature location of the approval document, and any other appropriate comments are to be entered on the appropriate screens in VetPro including: Service Chief's Approval, Committee Minutes, and Appointment Screens.
4. When indicated, appropriate documentation is to be entered into the Appointment screen of VetPro for less than full appointment, including Temporary and Expedited Appointments.
5. If at the time of initial evaluation, it is determined that no medical staff appointment or clinical privileges will be granted, this action is to be documented in the appropriate supporting documentation at the VA facility, i.e., committee minutes and a "Do Not Appoint" screen must be entered with appropriate comments. The electronic file then needs to be inactivated transferring the file to VetPro VA Central Office.

Section 11. Concurrent Appointments and Sharing of Files

1. In those instances where a practitioner is providing care at more than one facility, including telemedicine service, medical staff appointments at all facilities need to be coordinated and concurrent.
2. When the file is reopened for credentialing, each facility at which the provider holds a medical staff appointment needs to start the re-privileging process.
3. Instructions to the provider need to clearly state that:

- a. The re-privileging process is going to be done concurrently at all facilities.
 - b. The provider only needs to submit the renewal application in VetPro once, and
 - c. The provider must attest to each facility's Bylaws on the "Sign/Submit" screen.
4. Each facility needs to consider sharing the practitioner's responses to the Supplemental Questions and the references submitted as part of this coordinated credentials process. In coordinating this effort, the credentialers need to determine who is going to request documentation of any items identified on the Supplemental, the references, and/or peer appraisals.
 5. A facility may not use any time-limited verifications that are obtained prior to the practitioner attesting to the facility's Medical Staff Bylaws. Non-time limited information, such as education or training verification, may be used.
 6. Each facility needs to obtain the license verifications and document registration in the NPDB-HIPDB PDS.
 7. If at any point during the time a practitioner is shared, any of the facilities suspend the practitioner's privileges, or takes an action that is considered to be an adverse personnel, medical staff appointment, or privileging action, the facility taking the action must notify all facilities that share the provider of the action. This notification needs to be made to the COS of each facility for appropriate review and action within the privileges granted at the shared facility.

Section 12. Conversion of Appointments with No Change in Privileges

1. In those instances where a provider has held a specific employment or medical staff appointment and is being converted to a different type of appointment, either medical staff appointment or Title 38 appointment, the practitioner must apply for this
2. Prior to conversion all time-limited information must be verified, regardless of the period of time since previous verification.
3. The NPDB-HIPDB PDS registration must be confirmed.
4. The information obtained in this process must be evaluated and reviewed by the appropriate individuals in the same manner as initial appointments or reappraisal. This review must be documented in the appropriate minutes, as well as the credentialing and privileging folder and VetPro. The appointment date remains the same as the previous appointment with the expiration date not to exceed 2 years from that date.

ARTICLE VII. ORGANIZATION OF THE MEDICAL STAFF

Section 1. Leadership

1. The Chief of Staff is the President of the Medical Staff.
2. The Medical Staff, through its committees and organization of clinical service lines and sections, provides counsel and assistance to the Chief of Staff and Director regarding all facets of the clinical programs of the VAEKHCS, especially patient care services; research and educational programs; strategic planning involving identification of mission, vision, values, goals, and objectives; staffing and resource allocation; program evaluation; performance improvement activities; achievement of performance measures; internal peer review; external peer review; and decision-making about types of diagnostic and treatment modalities, delivery systems for patient care, and other relevant clinical issues.
3. All Medical Staff members in membership categories I and II, as defined in these *Bylaws*, are eligible for elected membership on the MEB.

ARTICLE VIII. COMMITTEES

Section 1. Medical Executive Board (MEB)

1. Chairperson:

As President of the Medical Staff, the Chief of Staff serves as permanent chairperson of the MEB.

2. Membership:

Deputy Chief of Staff, physician; permanent voting member

Medicine, SLM, physician; permanent voting member

Medicine, Associate SLM, physician; permanent voting member

Surgery and Surgical Specialties SLM, physician permanent voting member

Surgery and Surgical Specialties, Associate SLM, physician; permanent voting member

Behavioral Health SLM, physician; permanent voting member

Diagnostics SLM, physician; permanent voting member

(If Behavioral Health and Diagnostic Care Service Lines have physicians in the positions of Associate SLM, those individuals may also serve as permanent voting members.)

Geriatrics and Extended Care, SLM, physician; permanent voting member

Four (4) Medical Staff members appointed by the Chief of Staff, each serving up to 3-year terms; all voting members, with one being a mid-level practitioner

Four (4) rotating Medical Staff members to be elected by the Medical Staff, all voting members; one from each location (Topeka and Leavenworth) will be elected to a 2 year term, and one from each location will be elected to a 1 year term

Clinical Support SLM, permanent voting member

Pharmacy Manager, permanent voting member

Social Work Manager, permanent voting member

Associate Director for Patient Care Services/Nurse Executive, permanent voting member

Chief of Psychology, permanent voting member

Ex-Officio:

Director or designee; non-voting

Associate Director; non-voting

Coordinator, Quality Management and Performance Improvement; non-voting

Administrative Assistant to the Chief of Staff; non-voting

a. At least two-thirds of the voting members of MEB will consist of fully licensed physicians on the Medical Staff. All rotating Medical Staff members of the MEB will be elected by a majority vote of the Medical Staff, and will hold Category I or II Medical Staff membership, as defined in these *Bylaws*.

b. If a Medical Staff member who is elected or appointed as a rotating member of the MEB leaves the VAEKHCS or in some other way is unable to complete his/her term, the Chief of Staff has the authority to appoint another qualified Medical Staff member to the vacant position until such time as the entire Medical Staff meets and elects a replacement.

c. If there is a serious and compelling reason to remove an elected member of the MEB before the member's term has expired, removal requires a majority vote of the MEB and

concurrence by the Director. Within 30 days of the effective date of removal, the elected member has the right to request a meeting of the entire Medical Staff to appeal such removal. When this request is made, the meeting of the entire Medical Staff shall be held within 30 days of the date of the request. In addition, due process rights, fair hearing and appeal rights will be upheld.

3. The MEB will meet at least 6 times each year, or more often, as called by the Chairperson, and the meetings may be face-to face or video-conference sessions. Minutes of all proceedings will be, submitted to the Director for approval, distributed to members, and kept on file in the office of the Chief of Staff.

Attendance at MEB meetings is expected. If a member is unable to attend, a designated surrogate may substitute for the member, with the approval of the Chairperson, and the minutes will reflect it. JC standards mandate the attendance of the Chief Executive Officer (Director) or designee, who is expected to attend each MEB meeting on an ex-officio basis.

4. Functions of the MEB:

- a. Acts for the Medical Staff between medical staff meetings;
- b. Coordinates and directs Medicine, Behavioral Health, Surgery, Diagnostics ,Geriatrics and Extended Care, Pharmacy, Social Work and related patient care activities;
- c. Acts to ensure effective communication between the Medical Staff and the Director, and the Governing Body, as necessary;
- d. Provides liaison with management and the administrative services;
- e. Establishes and maintains (as a permanent arm of the MEB) the PSB which will report directly to the Director;
- f. Establishes standards for review of medical care activities and provides leadership for measuring, assessing and improving processed that primarily depend on the activities of the medical staff. Including:
 - (1) Medical assessment and treatment of patients.
 - (2) Adverse privileging information.
 - (3) Using of medications.
 - (4) Use of blood and blood components.
 - (5) Operative and other procedures.

- (6) Appropriateness of clinical practice.
- (7) Departures from established clinical practice.
- (8) Criteria for autopsy.
- (9) Sentinel event data.
- (10) Patient safety data.

These reviews are accomplished by clinical service lines and Medical Staff committees (and other committees) appointed for those purposes. The MEB is the coordinating mechanism.

- g. Receives and acts on reports and recommendations from Medical Staff committees/subcommittees, including those with quality of care and utilization responsibilities, clinical service lines, and assigned activity groups;
- h. Establishes an ad-hoc subcommittee or clinical review group to perform clinical case review or peer review of morbidity, mortality, or other adverse outcomes related to medical care. Such subcommittee or group will be appointed by the Chairperson of MEB and shall report findings, recommendations, and follow-up action to the MEB.
- i. Ensures that mandated functional reviews are accomplished;
- j. Reviews activities of the professional accreditation function to ensure compliance with appropriate JC and other accrediting body requirements and recommendations;
- k. Formulates reviews and updates Medical Staff functions. Such revisions are subject to final approval of the Director ;
- l. Receives, acts on and approves criteria for granting clinical privileges and scopes of practice for each Service Line or Service Line Section through PSB;
- m. Makes recommendations to the Director regarding:
 - (1) Structure and functions of Medical Staff;
 - (2) The types of medical care to be provided by the VAEKHCS, including those clinical services to be provided by telemedicine.
 - (3) Organization of performance and quality improvement activities of the Medical Staff as well as mechanisms used to conduct, evaluate, and revise such activities;

coordination of medical care related performance/quality improvement activities of the Medical Staff with the Performance Improvement Leadership Council;

(4) Mechanisms for fair-hearing procedures consistent with approved VA mechanisms;

(5) Medical Staff ethics and self-governance actions.

n. Reviews and recommends approval of policies on behalf of the Medical Staff. See provision in Article XII, Amendments, paragraph 2 of these *Bylaws*.

o. MEB reports to the Joint Leadership Committee (JLC).

Section 2. Professional Standards Board (PSB)

1. As defined in these *Bylaws*, the PSB is a permanent arm of the MEB. PSB recommendations are made to MEB and then recommended to the Director. PSB is the committee that has been delegated authority to recommend to the MEB on matters pertaining to initial appointment, reappointment, granting of initial or renewed clinical privileges or scope of practice/prescriptive authority for physicians, dentists, podiatrists, optometrists, psychologists and mid-level practitioners.

2. Composition:

The PSB is chaired by the Chief of Staff (who also serves as Chairperson of the MEB). The Chief of Staff selects members as required by the type of PSB, the action to be considered, and from a membership roster recommended biennially by the MEB and approved by the Director. At least two (2) members of each PSB shall hold membership on the MEB. The number of members and composition of each PSB is dependent upon the type of appointment or promotion being considered, consistent with VHA rules and regulations. A representative from Human Resources may be invited to PSB as a technical advisor.

3. Duties:

The purpose of the PSB(s) is to deal with appointments, promotions, and privileging of physicians, dentists and other appropriate staff, including the review and recommendation for granting scope of practice/prescriptive authority to mid-level practitioners. Further, the PSB determines eligibility and recommends appropriate grade for appointments and promotions under authority of 38 USC 7401(1), 7403, 7405(a) (1). The PSB can review performance and recommend disciplinary action or termination when initiated by the appropriate Service Line Manager (or senior physician in a Service Line section), or the Chief of Staff.

4. Meetings: The PSB meets at the call of the chairperson, and the proceedings are documented.

Section 3. Standing Committees of the Medical Staff

1. Medical Records Committee
2. Tissue and Transfusion Committee
3. Ancillary Testing Committee
4. Pharmacy and Therapeutics Committee
5. Infection Control Committee
6. Advisory Committee for Intensive Care
7. Dean's Committee
8. Residency Review Committee
9. Radiation Safety Committee
10. Long Term Care Council
11. Domiciliary Advisory Board
12. Education Committee
13. Patient Education Committee
14. Ethics Advisory Committee
15. Home Oxygen DME Committee
16. Computerized Patient Records (CPRS) Clinical Committee
17. Other VAEKHCS committees (non-Medical Staff) with significance for clinical staff:
 - a. Environment of Care Committee
 - b. Performance Improvement Leadership Council

Section 4. Medical Staff Standing Committee Records

1. Medical Staff standing committees will prepare and maintain minutes, utilizing the CRAFE format, that is, documentation of Conclusions, Recommendations, Actions, Follow-up, and Evaluation. Minutes shall be forwarded in a timely manner, through appropriate channels to the MEB.
2. Medical Staff standing committee minutes will be a mechanism to provide appropriate feedback in a timely way to SLM and other appropriate individuals/groups.
3. All standing committee findings, actions, and recommendations will be forwarded in an appropriate time frame to the MEB where review and further delegation of action will occur. The standing committee minutes will become a part of the minutes of MEB that will be sent to the Director for final approval.
4. MEB may receive minutes and recommendation from other clinical committees that are not listed above as standing committees.

Section 5. Committee Attendance

Medical Staff members are strongly encouraged to attend meetings of committees of which they are members. Punctuality at committee meetings is important. When a member is specifically

excused by the committee chairperson for appropriate reasons (such as, illness, leave, clinical requirements, etc.), the member will be listed as “excused” in the committee minutes. Committee minutes will specify members present, absent, or excused, and will identify as present any alternate or surrogate attendees. If a committee member is absent without legitimate reason from 3 consecutive committee meetings, the chairperson of the committee will send a written communication to the individual seeking better attendance and participation. If the member is unable to comply, the chairperson may replace the committee member.

ARTICLE IX. CLINICAL SERVICE LINES

Section 1. Characteristics

The Medical Staff will be organized to render medical care and services under the leadership of an individual qualified to assume responsibility for the services offered. Responsibility and reporting are done according to the EKHCS organizational chart.

The Medical Staff will be organized into the following service/lines:

a. Medicine Service Line

The Medicine Service Line includes the following sections and/or medical or clinical areas:

General Internal Medicine and associated subspecialties—Cardiology,
Pulmonology, Gastroenterology, Infectious Disease, Dermatology, Neurology,
Rheumatology and Nephrology

Inpatient and outpatient services
Intensive care

Dental services
Sleep Lab

b. Behavioral Health Service Line

The Behavioral Health Service Line includes the following:

Mental Health Services
Inpatient and outpatient services
Substance abuse, vocational and other special treatment programs
Domiciliary care program
PTSD
Case Management

c. Diagnostic Care Service Line

The Diagnostic Care Service Line includes the following:

Pathology and Laboratory Medicine
Radiology and Nuclear Medicine

d. Surgery and Surgical Specialties Service Line

The Surgery and Surgical Specialties Service Line includes the following:

General Surgery, Anesthesia, Ophthalmology, Orthopedics, Urology, Podiatry, and
Gynecology

e. Geriatrics and Extended Care Service Line

The Geriatrics and Extended Care Service Line includes the following:

Geriatric Medicine, CLC, Physical Medicine, Occupational and Physical Therapy,
Audiology and Speech Pathology.

f. Pharmacy Service

Pharmacy care and dispensing of pharmaceuticals

g. Social Work Service

h. Deputy Chief of Staff (DCOS) assists the Chief of Staff.

Section 2. Functions of Each Service Line

1. Provides for ongoing monitoring evaluation and assurance of quality, (including access, efficiency, and effectiveness feedback to staff); appropriateness of care and treatment provided to patients (including that provided under temporary privileges); patient satisfaction; risk management; and utilization management.
2. Assists in identification of indicators used to monitor quality and appropriateness of care.
3. Communicates effectively with the staff and keeps a record of service line meetings that include conclusions, recommendations, identification of persons responsible for actions, and evaluation of actions taken.

4. Develops criteria for recommending clinical privileges or scopes of practice for practitioners in the service line; collaborates with appropriate disciplines to develop functional statements and position descriptions.
5. Defines and develops a prototype document for clinical privileges to be used in the service line, based on the type of format deemed to be best suited for the department. Clinical privileges may be organized according to the concepts of core privileges, levels of privileges (graduated complexity), lists of procedures, or mixed formats. The MEB approves clinical privilege documents, as well as documents used for scope of practice/prescriptive authority for mid-level practitioners.
6. Develops and implements effective management, supervision, ethics, safety, communication, staff training and education, labor-management and employee relations, quality, and resource-budgetary activity within the service line.

Section 3. Selection and Appointment of Service Line Managers

A SLM (for a Medical Staff/Clinical Service Line) is appointed by the Director upon the recommendation of the Chief of Staff. SLMs who are physicians must be certified by the appropriate medical specialty board.

Section 4. Duties and Responsibilities of Service Line Managers

SLM are responsible and accountable for:

1. All professional or clinically related activities within the service line, including recruitment and selection orientation, continuing education and satisfaction of staff.
2. The monitoring and evaluation of the quality and appropriateness of the care and treatment of patients served by the service line, and the evaluation of clinical/professional performance of all individuals with clinical privileges or scopes of practice/prescriptive authority within the service line. For purposes of reappointment and renewal of clinical privileges or scopes of practice, practitioner-specific data will be utilized from the monitoring and evaluation of drug usage, specimen and blood review, infection control, medical record review, risk management including tort claims, utilization review, and other quality or performance measures.
3. Assuring that individuals with clinical privileges competently provide service within the scope of privileges granted, and individuals with scopes of practice competently provide services within the framework of their approved scopes of practice.
4. Recommending to the Medical Staff the criteria for clinical privileges in the Service Line (or medical specialty area) after development and approval of such criteria by Medical Staff members.

5. Identifying or defining clinical procedures that are site or location-specific, and developing a mechanism to assure that an individual authorized to perform site-specific procedures, as defined in policy and in the individual's clinical privileges or scope of practice, complies with such requirements. Site or location-specific clinical privileges are applicable to physicians, dentists, podiatrists, or optometrists. For mid-level practitioners, the scope of practice may identify site or location-specific procedures.
6. Recommending appointment and clinical privileges or scopes of practice for each Medical Staff member of the service line, and requesting the right for non-medical staff providers to practice under a scope of practice or functional statement, as appropriate and necessary, within the service line.
7. Overseeing administratively related activities of the service line, unless otherwise provided for.
8. Assessing and recommending to the Chief of Staff and/or the MEB the off-site sources needed for delivery of patient care, treatment, and services not provided by the service line or by VAEKHCS.
9. Assuring the integration of the service line into the primary functions of VAEKHCS.
10. Assuring the coordination and integration of inter-service line and intra-service line services.
11. Developing and implementing policies and procedures that guide and support the provision of care, treatment, and services.
12. Recommending sufficient numbers of qualified and competent persons to provide care, treatment, and services.
13. Determining the qualifications and competence of service line personnel who are not LIPs or mid-level practitioners, but provide patient care, treatment and service.
14. Maintaining quality control programs and continuous assessment and improvement of the quality of care treatment and services.
15. Ensuring the orientation and continuing education of all service line staff.
16. Recommending space and other resources needed by the service line.

ARTICLE X. MEDICAL STAFF MEETINGS

1. The entire Medical Staff meets at least once a year or at the call of the Chief of Staff.

2. Special meetings of the Medical Staff may be convened at the call of the Chief of Staff or the Director.
3. Medical Staff members will attend their service line staff meetings and meetings of committees of which they are members unless specifically excused by the service line manager or committee chairperson for appropriate reasons, (e.g., illness, leave or clinical requirements).
4. Category I & II members of the Medical Staff members will attend the annual meeting of the Medical Staff every year unless specifically excused by the Chief of Staff for appropriate reasons.
5. Category I and II members of the Medical Staff have voting rights in meetings of the entire Medical Staff.
6. Minutes of all Medical Staff meetings will reflect attendance, absences, issues discussed, conclusions, actions, recommendations, person(s) responsible for action/evaluation, and follow-up.
7. A quorum for purposes of the Medical Staff meetings shall consist of one third of the voting members, a majority of who must be physicians.

ARTICLE XI. RULES

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these *Bylaws* and in the guidelines of the Governing Body, subject to approval of the Director. Such rules and regulations shall be a part of these *Bylaws*. The *Bylaws* may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff or by electronic means in view of the geographic dispersion of the members.

Anything in these *Bylaws* that contradicts VA Handbooks or Directives is superseded by the Handbook or Directive.

ARTICLE XII. AMENDMENTS

1. The *Bylaws and Rules of the Medical Staff* will be reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the *Bylaws and Rules* and attendant policies may be submitted in writing to the Chief of Staff by any physician, SLM or member of the Medical Staff. All changes to the *Bylaws and Rules of the Medical Staff* will be submitted in meeting or electronically by the Chief of Staff to the MEB for review, discussion, comment and approval. Amendments approved in meeting or electronically by the MEB will be submitted to a vote by the active Medical Staff at the next meetings or by electronic means in view of the geographic dispersion of the members

2. Policies crucial to the functioning of the Medical Staff will be referenced in the *Bylaws* without being entirely outlined. When policies need to be further delineated, made more explicit, or when new policies need to be created or endorsed, the MEB may act on behalf of the entire Medical Staff when the Medical Staff is not in session. Final approval by the Director is required. The delegation of this approval process to the MEB constitutes an alternative and expedited approval process. Changes in policies shall be communicated to the entire Medical Staff in a timely way.
3. Written text of proposed significant changes, as well as notice of the date and time of the Medical Staff meeting, will be provided to members at least thirty (30) days before formal consideration in a Medical Staff meeting.
4. If an amendment proposed is in conflict with regulations, the chairperson of the MEB will make suggestions that would eliminate the conflict.
5. The proposed amendment will be voted at the next regular meeting of the Medical Staff or at a special meeting called for that purpose or by electronic means. To be adopted, an amendment will require a simple majority vote of the active Medical Staff present. In the case of electronic voting an amendment will require a simple majority of all the Medical Staff eligible to vote. Amendments so made shall become effective when approved by the Director.
6. All changes to the *Bylaws and Rules of the Medical Staff* require action by both the Medical Staff and the Director. Neither the Medical Staff nor the Director shall act unilaterally. Changes are effective when approved by the Director. The Bylaws of the Medical Staff may be amended by the Medical Executive Board.

ARTICLE XIII. ADOPTION AND SIGNATURES

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

Adopted by the Medical Staff of the VA Eastern Kansas Health Care System on this 10th day of September, 2009.

RECOMMENDED:

/s/

RAJEEV TREHAN, M.B.B.S, M.D., M.P.H.
Chief of Staff

APPROVED:

/s/

JUDITH L. JOHNSON-MEKOTA, FACHE
Acting Director

RULES OF THE MEDICAL STAFF

A. GENERAL

1. The Rules relate to the role and/or responsibility of members of the Medical Staff in the care of inpatients, emergency patients and ambulatory patients as a whole or to specific groups as designated.
2. Rules of service lines (departments or services) shall not conflict with each other, with the *Bylaws and Rules of the Medical Staff*, and with other policies of the Medical Staff or VAEKHCS, or with requirements of the Governing Body. Conflicts in rules of service lines shall be resolved by the Chief of Staff and/or the MEB.

B. PATIENT RIGHTS

1. Patient Rights and Responsibilities
 - a. The patient has the right to a reasonable response to a request and need for service within the capability and mission of the VAEKHCS, and within laws and regulations that pertain to the VA.
 - b. The patient has the right to humane, respectful, and equitable treatment at all times and under all circumstances. Every individual who presents to the VAEKHCS for care retains certain rights for privacy, not only the privacy of body, but also the privacy of disclosure. Therefore, all verbal or written disclosures of facts regarding a patient, other than to the patient, family, guardian or authorized VA and congressional inquiries, will be handled through the Health Information Management Section of the Health Administration and Finance Service Line. All written communications must be cleared through this Section. Proper consent must be obtained for photography of the patient.
 - c. The patient 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 prognosis. S/he has the right to expect adequate instruction in self-care in the interim between visits to the VAEKHCS. S/he has the right to know the identity of the physician who is primarily responsible for his/her care.
 - d. The patient has the right to contact the Service/Line for any reason, including voicing concerns or making complaints. The patient's exercise of this right will not be compromised in any way, except when it is determined to be clinically inappropriate due to safety concerns for the patient. The patient has the right of access to information about patients' rights and to information about the handling of patient complaints beyond the VAEKHCS.

- e. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his/her action. To the extent possible, the patient has the right to participate in deliberations of ethical decisions regarding his/her care.
- f. The patient has the right of access to information regarding any human experimentation or research/education projects affecting the patient's care.
- g. The patient has the right to (1) formulate advance directives; (2) appoint a surrogate for making health care decisions and for acting to exercise the patient's rights/wishes if the patient is judged incompetent in accordance with law, or is found by a physician to be medically incapable of understanding treatment, or is unable to communicate his/her wishes; (3) forego or withdraw life-sustaining treatment including resuscitation.
- h. The patient is responsible for:
 - (1) providing the physician and other health care providers with complete and honest information;
 - (2) cooperating with the treatment plan developed for and with him/her;
 - (3) following all safety rules and posted signs at the facilities of VAEKHCS; and
 - (4) not interfering with the treatment of other patients, especially in emergency situations.

2. Advance Directives

"Living Will" and "Durable Power of Attorney" are legal mechanisms that allow patients to have their previously declared specifications for medical care or life support (or withdrawal of such care or support) enforced when they are not well enough to assert them. Any competent patient may execute such a declaration. VAEKHCS policies define and outline specific procedures related to Advance Directives.

3. Informed Consent

The patient has a right to know which practitioner is responsible for the performance and/or the supervision of a contemplated procedure or treatment. An explanation in sufficient detail to permit an informed consent will be given to the patient by the provider. If the practitioner informing and counseling the patient will not be the one to perform the procedure, the patient should be so advised and should be given the name of the individual(s) who will be performing the procedure. (In addition, see E. in these Rules, and VAEKHCS policy relating to Informed Consent.)

C. GENERAL RESPONSIBILITY FOR CARE

1. Responsibility for the Conduct of Care

A physician who is a qualified and privileged member of the Medical Staff shall bear primary responsibility for the management and coordination of medical care of each patient in the VAEKHCS. The physician is responsible for coordinating the information and therapeutic efforts of all the other professional disciplines involved in the care of the patient. As defined in these Rules (Rule C. General Responsibility for Care, Paragraph 4, below) the multidisciplinary treatment team approach will be utilized to provide patient care.

2. Emergency Services

The Dwight D. Eisenhower VA Medical Center and the Colmery-O'Neil VA Medical Center, (both medical centers in the VAEKHCS) have been designated as a JC Level III Emergency Services facility. Emergency care consistent with a Level III facility is offered 24-hours per day with at least one physician available at all times. Qualified specialists on the Medical Staff shall be available as needed for consultation. If a suitable specialist is unavailable or if it is felt that the needed services cannot be provided in the VAEKHCS, the patient will be transferred to a hospital where definitive care can be provided.

3. Admissions

- a. Any applicant appearing in person will be given a physical, psychological, and social assessment promptly to determine the need for care.

(1) Requirement for Provisional Diagnosis

Except in an emergency, no patient shall be admitted to either of the medical centers in VAEKHCS until a provisional diagnosis has been documented in the medical record. VAEKHCS shall admit legally-eligible persons, as defined by law and applicable VA regulations, suffering from any type of disease or injury which, in the opinion of the admitting medical professional, should and can be treated on an inpatient basis at the VAEKHCS; or should be admitted for humanitarian reasons until the patient may be transferred to a health care facility equipped to care for the disease or injury. Medical Staff members will examine and make the proper disposition of all eligible applicants.

(2) Humanitarian Admission

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

(3) Admitting Rights

Physician members of the Medical Staff may admit patients for inpatient care. Resident physicians (trainees) may admit patients for inpatient care under the supervision of a physician member of the Medical Staff. Other members of the Medical Staff (such as dentists, podiatrists, optometrists or psychologists) and mid-level practitioners may admit patients, if admission is approved by a physician on the Medical Staff, and if required aspects of inpatient care are provided/overseen by a physician on the Medical Staff. Only licensed physicians and dentists may reject patients for medical care.

(4) Consultation for Specialty Services Admission

All medical and medical specialty admissions are routed through the hospitalist. If a consultation is needed for an urgent patient care need to another service (i.e., Behavioral Health or Surgery) and there is no response to the urgent referral within a reasonable time (time frame dictated by the Veteran's condition), the individual will be transferred to another facility for urgent care.

- b. All patients will be attended by members of the Medical Staff who have clinical privileges for the treatment of the type of condition that requires hospitalization.
 - 1. Each practitioner is held responsible for the medical aspects of a patient assigned and will not delegate or transfer this responsibility to another practitioner who is not qualified for this undertaking.
 - 2. The Medical Staff in attendance will maintain a complete, current and legible medical record for each patient. The medical record will include identification data; chief complaint; past medical history; family history; history of present illness; physical examination; special reports; progress notes; provisional diagnosis(es); final diagnosis(es); and a discharge summary which includes the condition of the patient at the time of discharge and a plan for continued care of the patient.
- c. Any direct medical care provided to patients by members of the house staff (resident physician trainees) or by allied health personnel will be supervised by the licensed physician assigned responsibility for the care of the patient.
- d. History and Physical Examination.

A history and physical examination (H&P) that includes present and past medical history, family, and social history to include military (if not previously documented) and occupational history, and inventory of body systems. A present and past medical history, physical examination, system review and initial plan of care including provisional diagnoses shall be performed and documented by a physician, PA, or APRN within 24 hours of admission of the patient to an inpatient unit. In Psychiatry, this will include a psychiatric history. If it is anticipated that a dictated H&P may not be incorporated into the medical record within 24 hours of a patient's admission, then a progress note containing pertinent information and findings to enable clinicians to manage the patient

and guide the plan of care should be placed in the medical record within the first 24 hours of a patient's admission. (Also see Rule I, Medical Records, 3. Inpatient Records, paragraph a., of these *Bylaws and Rules*.)

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

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

g. In those instances when a patient is admitted within 30 days following the date of the latest prior complete H&P (performed on an inpatient or outpatient basis), an interval H&P reflecting any subsequent changes may be used in the medical record. An interval history and physical exam, when used, will be entered in a progress note and will contain the following:

1. A statement that the previous H&P has been reviewed;
2. A statement that there are pertinent additions to the history/and or subsequent changes in the physical findings which will be specified;
3. A statement indicating there is no change noted in the review of the previous history and physical examination.

This is permitted if it is medically determined that such an exam, in conjunction with the prior exam, is adequate to reflect a comprehensive and current physical examination. In all cases where surgery is performed, the medical record will show documentation of a complete H&P performed within the past 30 days, or an interval H&P progress note, as described above, with the exception of any surgical procedure for which an exception has been made to this rule. The requirement for H&P for certain minor or simple surgical and medical procedures has been waived by action of the MEB, acting on behalf of the Medical Staff. A list of these procedures will be provided to all Medical Staff members and distributed widely in the VAEKHCS. For cases where the H&P examination is required, this documentation must be in the medical record prior to the surgical operation or procedure. In an emergency, when there is no time to record the complete H&P, a note on the preoperative diagnosis is recorded before surgery.

h. Readmission on or after the 31st day after the date of the latest prior H&P will require completion of a current H&P.

i. History and Physical Examination

Performance of History and Physical Examination by Practitioners other than Medical Staff

1. Medical and psychiatric histories, physical examinations, and system reviews may be accomplished by qualified individuals other than members of the Medical Staff, specifically resident physician trainees, PAs, and APRNs, when such responsibilities are defined in the individual's scope of practice. The physician assigned responsibility for the care of the patient must review such H&Ps. An appropriate entry indicating review and concurrence (or differences) must be made by the physician in the medical record as soon as possible. Concurrence in the medical record prior to any major diagnostic or therapeutic intervention is required. Any difference will be documented by amending and co-signing the H&P.
2. The above responsibilities also apply to medical and psychiatric outpatient settings. However, full physical examinations and system reviews are not required and are done to the extent that they are necessary and appropriate. The minimal level for a medical evaluation in an outpatient setting is a physical screening.
3. Other components of an inpatient and outpatient assessment may include a history of and screening for substance abuse, mental status exam or screening, military history, and psychosocial history. Physicians and other qualified professionals (when defined in their scope of practice, functional statement or position description) may perform these duties. In a substance abuse treatment program, qualified addiction therapists may perform and document history-taking/screening for substance abuse, mental status exam or screening, military history, and psychosocial history if these duties are identified in their position descriptions and defined in protocols approved by the MEB. These medical record entries by qualified addiction therapists will not require co-signature by the patient's physician.
4. Qualified podiatrist and dentist members of the Medical Staff are responsible for completing the parts of H&P that relate to podiatry and dentistry, respectively. Qualified oral surgeon members of the Medical Staff who admit patients without medical problems may perform the H&P on these patients if they have such privileges, and may assess the medical risks of the proposed surgical procedure. Qualified PAs, APRNs and others may perform the entire H&P if such authorization is given in the individual's scope of practice.

j. Laboratory and Radiology Examination

Each patient admitted to inpatient care shall have appropriate laboratory and x-ray examinations in accordance with the current standards of care in the particular area of medical practice. When ordering diagnostic examinations, the practitioner shall provide

adequate and pertinent information in the DHCP order/entry mechanism. Each Service Line with inpatient beds may specify in its policy and procedures manual the examinations that are to be routinely obtained on patients admitted to the Service Line.

k. HIV Counseling

When HIV testing is indicated, it is the responsibility of the practitioner to ensure that HIV counseling is accomplished and the appropriate consent form is completed prior to conducting HIV antibody testing.

l. Intensive Care Unit(s) (ICU)

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

4. Multidisciplinary Treatment Planning

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

5. Transfers

a. Transfer to a non-VA Medical Center

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

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

(3) Patients will not be transferred between facilities until the patient's care has been discussed and documented between the referring and accepting physicians.

(4) A medical records entry will document:

- Reason for transfer
- Alternatives to transfer
- Accepting facility
- Accepting provider
- Patient/family education about further care and alternatives
- Patients physical and psychosocial status
- Summary of care, treatment, and service provided and progress toward goals
- Community resources or referrals provided to the patient
- Accountability and responsibility for patient's safety during transfer

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

b. Inter-facility Transfers

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

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

(3) Patients will not be transferred between facilities until the patient's care has been discussed between the referring and accepting physicians.

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

c. Transfers within the Medical Center

1. Patients shall not be transferred from one service line or section, or out of an ICU or from the recovery room without a written order by the Medical Staff member responsible for the patient's care.
2. Transfers from one service line to another will be accomplished by the mutual agreement of the service lines involved.
3. There shall be a transfer note written on the progress notes by the responsible Medical Staff member transferring the patient to another physician's care. It shall be a concise recapitulation of the medical course to date, developed to assist the Medical Staff member who assumes responsibility for the continuity of inpatient Care.
4. The unit clerk or nursing staff members will be responsible for promptly notifying the responsible receiving staff as soon as the new patient has arrived on the unit.
5. ICU will accept critically ill patients meeting the criteria established by the clinical service lines and the Advisory Committee for Intensive Care, and approved by the MEB. Persons having a DNR order will be maintained or transferred into ICU only when sufficient beds and nursing resources are available. Exceptions can be made by the Medical Director(s) of the ICU(s), the Medicine SLM, or by the Chief of Staff.
6. Consultations
 - a. Good medical judgment should always be exercised in the initiation of consultation requests in order to avoid overburdening the consulting section, department or individual. Consultations should be requested for valid medical reasons. They should be written clearly, setting forth the problem and the information requested. They may be written by physicians, dentists, podiatrists and optometrist members of the Medical Staff. Midlevel practitioners and other qualified professionals may request medical consultations when such authority is defined in their scope of practice. Non-medical consultations (e.g., psychological testing; etc.) may be requested by professionals who have this included in their scopes of practice.
 - b. Depending on patient needs, psychiatric consultation may be recommended for psychiatric patients assigned to service lines other than Behavioral Health. Psychiatric consultation is required for patients who have attempted suicide or have taken a chemical overdose while on authorized absence or in the hospital.
 - c. Except in an emergency, consultation with another qualified professional should be considered when, in the judgment of the patient's responsible clinical staff member;
 - (1) The patient is not a good risk for operation or treatment;
 - (2) The diagnosis(es) is obscure;

- (3) There is doubt as to the best therapeutic measures to be utilized.
- d. A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical Staff, based on the individual's training, experience, and competency.
- e. The responsibility of determining policy for answering medical consultation requests rests with the clinical SLM and/or clinical supervising physician in the service line sections providing the consultative services. Time frames for responding to consultation requests and documenting consultations in the medical record shall be approved by the MEB and communicated to the Medical Staff. The basic philosophy of the Medical Staff is to provide medical consultation with a high level of professional competency, efficiency and promptness.
- f. A satisfactory consultation includes examination of the patient and the records. A written opinion and recommendation(s) signed by the consultant must be included in the patient's medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.
- g. Unless otherwise indicated in the requesting practitioner's consultation request, it is assumed that consultants may write orders and/or provide treatment for the patient for whom consultation is requested.
- h. Consultation within VAEKHCS does not represent referral or transfer of care. For consultation involving the transfer of care to another VA medical center, the Network (VISN 15) policy prevails.
- i. Medical ethics should be followed in consultations. The findings and opinions of the consultant should be limited to the clinicians involved. Patients, their representatives and families should not be apprised or advised by the consultant, except with the attending staff member's prior knowledge and consent.
7. Discharge Planning
- a. Discharge planning in the VAEKHCS is a process by which staff collaborates with the patient and significant others to develop an individualized plan for continuing care. Patients and their families or significant others shall have active involvement in developing the discharge plan whenever possible. The planning and involvement of the patient will be documented in the medical record.
- b. Discharge planning begins as early as a determination of need is made by the evaluation of discharge potential and resources.

- c. The discharge plan shall be designed to assist the patient in reaching his or her optimum activity level and shall address post-hospital adjustment issues, including the services necessary to ensure continuity of care to meet the patient's needs.
- d. Particularly difficult discharge planning problems may require consultation with the SLM or Chief of Staff who may convene a group of professionals to recommend options.

8. Discharge

a. From Inpatient Status

(1) The release of an inpatient from VA hospitalization or nursing home care depends on the following medical decisions:

- (a) The patient does not require continued services which are only available to an inpatient; and
- (b) All indicated outpatient medical needs, nursing, or home care services are suitably arranged in advance of the patient's release from the VAEKHCS.

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

(3) Patients shall be discharged only on written order of a physician or other professional qualified and permitted by clinical privileges or scope of practice to discharge patients. No discharge will occur without adequate provisions for continued follow-up care.

b. From Intensive Care Unit

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

c. From Post-Anesthesia Recovery

The release of every patient from the post-anesthesia recovery area shall be in accordance with recovery room policy, i.e. discharged on order of the anesthesiologist or the physician/surgeon caring for the patient. If the anesthesiologist or the physician/surgeon

caring for the patient is not available, the patient may be released from the recovery area if his/her clinical condition meets previously approved discharge criteria.

d. Discharge Summary

Discharge summaries will be documented prior to discharge, or within 24 hours of death or irregular discharge. Discharge summaries upon death will include the time and date when the patient expired, and the events leading to the death must be recorded by the physician.

9. Autopsy

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

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

10. Diagnostic Tests Performed under Sharing Agreements

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

D. PATIENT CARE ORDERS

1. General Requirements

a. Patient care orders by physicians must be written within the limits of licensure, current clinical privileges and in accordance with good medical practice. Orders by resident physicians shall be governed by the VA policies regarding supervision of residents. Orders given by dentists, podiatrists, optometrists and psychologists shall be governed by relevant VA policies.

b. When specifically authorized by the individual's scope of practice, mid-level providers may write patient care orders, and these orders shall not require co-signature by the supervising physician. When so authorized in a dietitian's scope of practice, the qualified clinical dietitian may write orders, without co-signature by the supervising physician, for regular and modified diets, including oral or enteral support regimens, and shall document

such diet prescription in the patient's medical record. The clinical dietician may also recommend and write parenteral nutrition prescriptions with the co-signature of the authorized provider. When so authorized in the scope of practice, the Infection Control Coordinator(s) may write orders for specified laboratory tests and may initiate isolation precautions when appropriate. All professional groups providing care and service to patients in VAEKHCS shall honor appropriately given orders from qualified mid-level practitioners practicing within approved scopes of practice/prescriptive authority.

c. It is a requirement for all medication orders to be entered electronically through the Provider Order Entry (POE) system. Orders are not to be handwritten. This is a requirement for all providers with prescriptive privilege or authority, including physicians, dentists, podiatrists, optometrists and psychologists no matter what their status, and also all resident physician trainees, and all mid-level practitioners. There may be some exceptions to this rule that will be governed by the Chief of Staff and the MEB—for example, outpatient orders for schedule II controlled substances, total parenteral nutrition (TPN), and a few others.

d. All orders must be complete and clear, and if handwritten, legible. All orders shall include the date.

e. No order will be altered after it is written. An order that is in error or written by mistake shall be canceled or discontinued and a separate correct order written if needed.

f. Routine or standing orders for a practitioner, when applicable to a given patient, will be reproduced in detail in the patient's medical record by the ordering individual.

g. When conflict or disagreement arise over patient care orders or when physician/other practitioner orders for patients are unclear, controversial or considered unsafe by the employee receiving and/or carrying out the order, it is the responsibility of the registered nurse, registered pharmacist or other professional practitioner to use established VAEKHCS policy/procedure to resolve such problems. The registered nurse or pharmacist first contacts the physician (or other medical practitioner who wrote the patient care order) and discusses the issue. If the matter is not resolved in this way, the employee then contacts his/her immediate supervisor. The nursing or pharmacy (or other, as appropriate) supervisor will contact the appropriate physician, SLM or the Chief of Staff to seek resolution of the problem. Registered nurses and registered pharmacists and their supervisors, the physician/other practitioner issuing patient care orders, and supervisory/management physicians all have responsibilities in such situations. Involved individuals may not ignore or postpone discussion and resolution of problems related to orders for patients.

2. Medication Orders

Medications shall meet applicable professional standards and all applicable federal laws and VA regulations and guidelines.

- a. Medication orders will include the following information:
 - (1) Patient name
 - (2) Date
 - (3) Name of medication, generic preferred, if appropriate
 - (4) Dosage (metric is preferred), and strength, if appropriate
 - (5) Route of administration
 - (6) Frequency of administration. "PRN" and "on call" orders must be qualified.
 - (7) Duration of the order
 - (8) Signature-- It must be a full signature (written or electronic) with the designation identifying the profession of the Medical Staff member.
- b. "Renew", "repeat", "as directed" and "continued" orders are not acceptable. All orders must be completely rewritten to include specifics such as drug, dosage, frequency and route.
- c. Range dose prn policy: Range dosing (with variable dose or variable time between doses) are not acceptable. The ordering practitioner must identify the condition for giving one dose of medication and the conditions for giving a different dose.
- d. Drugs brought into the VAEKHCS by patients shall not be used unless they have been identified and the physician or other practitioner has given specific written orders to utilize them. Current policies related to the security and/or disposition of such drugs will be followed.
- e. Self-administration of drugs by patients shall be permitted only if specifically ordered by a medical staff member and after explanation of their use to the patient.
- f. The Pharmacy maintains a medication profile for each patient.
- g. To the extent possible, Medical Staff will protect the security of VA prescription pads.

3. Standing or Pre-Printed Orders

- a. Standing or pre-printed orders are electronic templates that commonly apply to patients of like category or to the special ordering requirements of an individual provider or group of providers. Standing or pre-printed orders must be approved by the appropriate clinical SLM and by the MEB.

- b. These orders will be used only to the extent that they expedite patient care and treatment.
- c. These orders will be carried out only after they are reviewed, dated, and signed by the responsible physician.
- d. Standing orders (written protocol approved by the MEB) for treatment of specified life-threatening conditions in the Intensive Care and Telemetry Unit(s) may be implemented by qualified registered nurses in the absence of a physician.

4. Automatic Stop Orders for Inpatient Medications

- a. All previous orders, including drugs, will be automatically continued when a patient transfers from one unit, section, or service line to another, except when a patient goes to the Operating Room or when a patient enters the Domiciliary.
- b. The use of narcotics and controlled substances for inpatient use shall be limited by the following stop orders:
 - (1) Orders for Schedule-II controlled substances shall be automatically stopped after 72 hours, except for the CLC, where initial orders for Schedule-II controlled substances may be 14 days if specified by the ordering practitioner. . Fourteen (14) day extensions for Schedule-II controlled drugs may be ordered by the physician or responsible practitioner if s/he has evaluated the patient's condition and determined there is a need for a longer duration of therapy.
 - (2) Schedule-III through Schedule-V controlled substances and alcohol must be reordered by the physician every 28 days.
- c. All other orders expire at the end of 28 days, except in Extended Care and CLC, where orders are effective up to 90 days.
- d. Automatic stop dates will apply in the following cases:
 - (1) Antibiotics (oral) non-specified time frame: 10 days
 - (2) Antibiotics (parenteral) non-specified time frame: 7 days

After 3 days, the physician will be contacted by the Pharmacy to determine if the parenteral antibiotic is to be continued.

 - (3) Continuous large volume parenteral admixture for up to 72 hours.

(4) Parenteral nutrition every 24 hours until stabilized, then for up to 72 hours if specified.

(5) Anti-coagulant drugs used for acute phase anti-coagulation on hospitalized patients must be reviewed and rewritten by the responsible medical staff member every 24 hours, if usual good medical practice requires that their use be monitored by daily laboratory tests of coagulation parameters. Dosing nomograms for anti-coagulant drugs approved for use by the Pharmacy & Therapeutics Committee may extend this interval to 72 hours, unless a shorter period of time is specified by the prescriber.

(6) For hospitalized patients on maintenance and/or long-term anti-coagulation by Coumadin, the prothrombin time will be regulated at the discretion of the prescribing practitioner, not to exceed every 14 days.

e. An automatic stop order does not apply when the number of doses in an exact period of time is specified.

5. Verbal/Telephone Orders

a. Verbal/telephone orders may be given by physician, dentist, podiatrist, or optometrist members of the Medical Staff or by other qualified professionals if such authority is given in the individual's scope of practice.

b. All registered nurses, registered pharmacists, PAs, registered dietitians, and certified respiratory therapists may accept verbal orders, within their scopes of practice or functional statements/position descriptions. Medical technologists in Pathology and Laboratory Medicine may accept verbal requests when a test is added to a specimen already accessioned into the laboratory computer, or a test may be added to an existing order number.

c. Verbal and telephone orders are discouraged. Despite our best efforts, they always carry some risk of error, and for this reason, they should not be used except when required by an urgent or necessary situation, as described in subparagraphs (1) and (2) below. Provider Order Entry (POE) is a system that has been mandated for the purpose of preventing and reducing errors. Handwritten verbal or telephone orders may not be honored by the Pharmacy. They must be processed electronically.

(1) Verbal/telephone orders shall be used only in emergency situations or in circumstances such as evenings, nights, and weekends when the medical professional directly involved with the patient's care is off the unit and the telephonic orders are the most practical and expeditious means of continuing the patient's care.

(2) Verbal/telephone 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/her to arrive at the bedside.

(3) All verbal/telephonic orders shall be read back, word for word, for the purpose of confirming the original order, and will be entered in the patient's electronic medical record. The notation will include the name and title of the issuing individual and the receiver, as well as the date, time and order. This read-back requirement also applies to the telephone reporting of critical diagnostic test results.

(4) Repeat violators of this regulation will not be provided this privilege.

d. Verbal/telephone orders will not be given or received for the purpose of imposing a Do Not Resuscitate (DNR) order or for the use of investigational drugs.

e. All verbal/telephone orders must be authenticated within 30 calendar days after the discharge of the patient by the Service Line.

6. Investigational Drugs

a. Investigational drugs, including unapproved usage of a FDA-approved drug for investigational purposes, may be used when cleared through a Human Studies and Research Committee and/or after review by the Pharmacy and Therapeutics Committee.

b. Patients enrolled in VAEKHCS have the right to participate in research protocols involving investigational drugs that have been approved at other sites. When those patients are admitted to VAEKHCS for inpatient care, the Pharmacy will keep and dispense the investigational drugs through normal pharmacy channels. A facsimile of the Federal Drug Administration (FDA) investigational drug information sheet will be filed in the front of the patient's medical record, and a notation regarding the FDA information sheet will be entered into the electronic medical record in the Patient Alert section. When the research study has been approved in any VA site, a facsimile of the signed, informed consent for the investigational study (VA Form 10-1086, "VA Research Consent Form") will be filed in the front of the patient's medical record, and a notation regarding the investigational drug and the informed consent will be entered into the electronic medical record in the Patient Alert section.

E. INFORMED CONSENT

1. VHA Handbook 1004.1, "VHA Informed Consent for Clinical Treatments and Procedures," is the definitive policy for informed consent in VAEKHCS, and any local policy will be based on the national handbook.

2. Before any surgical operation or certain other specified diagnostic/therapeutic procedure is performed, a "Request for Administration of Anesthesia and for Performance of Operations and Other Procedures", (Standard Form 522) must be completed, signed by the patient and witnessed. The procedures/treatments requiring consent are listed in separate VA publications.

3. A patient may revoke the consent at any time, even verbally; if so, a new consent form must be completed before proceeding.
4. The scope of consent may be limited to a one-time, single treatment or procedure, or may encompass consent for routine care of a particular problem or condition (such as asthma) or for a series of treatments (such as dialysis or blood transfusions). When the proposed treatment plan involves multiple or recurrent treatments or procedures, it is generally not necessary to repeat the informed consent discussion. There are, however, two (2) circumstances where the informed consent must be repeated and a new consent must be obtained:
 - a. If there is a significant deviation from the treatment plan to which the patient originally consented; or
 - b. If there is a change in the patient's condition or diagnosis that should reasonably be expected to alter the original informed consent.
5. In the event of a significant change in the patient's condition that might alter diagnostic or therapeutic decisions, the consent will be deemed automatically rescinded.
6. The responsibility for providing information and for obtaining consent is that of the practitioner who has primary responsibility for the patient or who will be performing the procedure/treatment. (See Rule B.3. in these Rules.) A mid-level practitioner may obtain consent, within his/her scope of practice, and for which s/he has discussed or explained to the patient.
7. According to provisions in VHA Handbook 1004.1, "VHA Informed Consent for Clinical Treatments and Procedures," the physician SLM or Chief of Staff may serve as surrogate or substitute next-of-kin and may sign consent in cases where an emergency procedure must be performed on a patient without decision-making capacity, and the next of kin or other designated surrogate is unavailable or there is no other surrogate.
8. The signature acknowledging consent must be witnessed. The witness cannot be a member of the clinical team involved in the procedure. The witness shall not be a minor or a relative of the patient.
9. If telephonic consents are necessary, it is required that the recorded conversation between the provider, the individual giving consent, and the witness is transcribed prior to the performance of the procedure, unless there is some mitigating clinical situation that makes such transcription impractical or contrary to sound practice. The Medical Staff expects that transcription of telephonic consents will be performed expeditiously and kept current.
10. An entry must be made in the medical record, prior to the procedure or treatment, which documents:

- a. The date and time consent was given.
- b. The patient's condition at the time the information was provided and consent given.
- c. The name(s) of the practitioner(s) immediately responsible for the performance, and if applicable, the supervision of the procedure or treatment.
- d. A brief description of the proposed care, treatment, services, medication, intervention or procedures.
- e. Potential benefits, risks, or side effects, including potential problems that might occur during recuperation.
- f. The likelihood of achieving goals.
- g. Reasonable alternatives.
- h. When indicated, any limitations on the confidentiality of information learned from or about the patient.
- i. The relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment, and services.
- j. The fact that relevant aspects of the procedure/treatment, the indications, risks, benefits, and alternatives have been discussed with the patient in language understandable to him/her.
- k. The fact that the patient had the opportunity to ask questions and to indicate comprehension of the discussion.
- l. The fact that the patient freely consented to the procedure/treatment without duress or coercion.

11. In the event of a refusal or revocation of consent, documentation that the consequences of the refusal or revocation were discussed with the patient will be entered into the medical record.

F. GENERAL RULES REGARDING SURGICAL CARE

1. In the VAEKHCS, a surgical operation is defined as the “manipulation of human tissue by qualified physicians, dentists, or podiatrists for the purpose of diagnosis or treatment.” The following procedures are excluded from this definition, and are not generally considered surgical operations: venipuncture, arterial puncture, administration of intravenous contrast agents or radiopharmaceuticals, administration of intravenous fluids or blood transfusions, intra-muscular

injections, subcutaneous injections, intra-dermal injections, and lumbar puncture. This list may not be exhaustive of the procedures not considered surgical operations.

2. Surgical procedures should be scheduled in advance of hospital admission, unless of an emergent nature.
3. An operation, other than an emergency, shall not be performed until adequate clinical data, as determined by Surgery and Surgical Specialties Service Line, is recorded in the medical record.
4. When the H&P is not recorded prior to an elective operation or any potentially hazardous diagnostic procedure, the procedure will be postponed until the H&P is recorded. In an emergency, when there is insufficient time to record the H&P, a note on the preoperative note is recorded before surgery.
5. The requirement for H&P for certain minor or simple surgical and medical procedures has been waived by action of the MEB, acting on behalf of the Medical Staff. A list of these procedures will be provided to all Medical Staff members and distributed widely in VAEKHCS.
6. An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
7. The operative or other high-risk procedure report includes the following information:
 - The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
 - The name of the procedure performed
 - A description of the procedure
 - Findings of the procedure
 - Any estimated blood loss
 - Any specimen(s) removed
 - The postoperative diagnosis
8. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and assistant(s), procedures performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.
9. There shall be written guidelines developed by an anesthesiologist for the safe use of all anesthetic agents used in the hospital. When the operating anesthesia team consists entirely of non-physicians, a physician must be immediately available in case of emergency.

a. Anesthesia Standards

Standards of anesthesia care will be consistently implemented in all areas of the VAEKHCS.

b. Standards of anesthesia care include:

- (1) Pre-anesthesia assessment of the patient;
- (2) Pre-induction plan for implementation of anesthesia;
- (3) Discussion of the plan with the patient and/or family;
- (4) Monitoring and assessment of the patient's physiological status during the procedure;
- (5) Post-procedural assessment;
- (6) Documentation of all levels of care, including the description of the presence/absence of anesthesia-related complications; and
- (7) Appropriate post-procedure instructions to the patient.

c. The administration of anesthesia shall be in accordance with the established policies and procedures of the Anesthesia Section.

d. Anesthesia standards shall apply for general, spinal or other major regional anesthesia, or for sedation (with or without analgesia) for operative or other invasive procedures for which there is reasonable expectation that, in the manner, used, the sedation or analgesia will result in the loss of protective reflexes for a significant percentage of a group of patients. Where there is any expectation that any percentage of a group of patients could experience the loss of protective reflexes, the member of the Medical Staff responsible for IV sedation should be qualified and privileged to care for the patient and/or qualified personnel should be immediately available.

e. In the VAEKHCS, the term "loss of protective reflexes" will mean the obtundation of the patient's reflexes sufficient to threaten the existing, pre-procedural physiological status of the patient. Protective reflexes are defined as any responses that preserve the safety of the patient. Protective reflexes include but are not limited to the maintenance of the patient's airway to provide for adequate ventilation and prevention of aspiration.

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

11. All operations will be performed or supervised by the attending physician. The operating surgeon shall have a qualified physician or mid-level provider as an assistant in all major operations.

12. Specimens for Pathologic Examination

Verification of the removal of all operative specimens must be routinely accomplished. Tissues and other material removed during medical/surgical and/or dental procedure must be appropriately labeled and sent to the pathologist for pathological examination. All specimens must be accompanied by a properly completed tissue exam request form.

13. Specimens exempt from pathological examination include:

- a. Tissue that by nature or condition does not permit objective examination, such as sonicated cataracts, tissues containing therapeutic radioactive sources.
- b. Bullets which are always required to be given directly to law enforcement representatives for legal reasons.
- c. Teeth and/or tooth structures elements (tooth fragment and/or bone, dental appliance.
- d. Parings of hyperkeratotic lesions, warts and calluses.
- e. Toenail Clippings.
- f. Superficial debridement wound material.
- g. Clinically normal skin removed during repair defects procedures such as dog ear repair that follow a previously diagnosed lesion.
- h. Catheters and/or tubing upon discontinuation of their usage.
- i. Tiny skin tags measuring 1 or 2 mm safely considered as benign. Microscopic examination will be performed at the discretion of attending.

These exempted from pathological examination tissue specimens will be properly disposed in biohazard bags. Documentation of tissue removal and disposal should be incorporated in the procedural note.

Radioactive material will be checked for radioactivity and any refuse reading more than the background levels of radiation will be decontaminated and moved to Nuclear Medicine for decay until they register under the required limit, then disposed in biohazard bags.

14. The following specimens will have “gross examination only”, unless otherwise requested by attending or decided upon by the Pathologist:

Calculi and gravel, urogenital prostheses, orthopedic hardware, foreign bodies, shrapnel, toenails, hammertoes, normal bone from abnormal location (exostosis) or incidentally removed (example, rib during thoracotomy or part of amputations performed for non-osseous pathology) and torn meniscus.

G. SPECIAL TREATMENT PROCEDURES

1. Withholding of Life Support

a. Advance Directives

The Medical Staff of VAEKHCS is committed to supporting and sustaining life. In some cases of illness, however, the physicians and staff cannot prevent a patient's death or alter the course of the disease, and further medical intervention merely extends the dying process. In such circumstances, some patients believe that additional special efforts are a burden on themselves and their family. Part of the professional commitment of the Medical Staff is a respect for the wishes of the patient concerning the types of care received.

A declaration of withholding of life support must be signed by the patient in the presence of two witnesses, neither of whom are:

- (1) Related to the patient by blood or marriage;
- (2) Entitled to, or a claimant against, any portion of the patient's estate;
- (3) Financially responsible for the patient's care; or
- (4) An employee of the VAEKHCS, unless other witnesses are not reasonably available. In that case, employees such as chaplains, social workers or non-clinical employees may serve as witnesses.

b. Withdrawal of Treatment

- (1) Circumstances under which treatment may be withdrawn or withheld:
 - (a) In the judgment of the attending physician, application of specific medical intervention offers no overall medical benefit in altering the course of the disease;
 - (b) A competent patient personally requests that a specific treatment be withheld or withdrawn;

(c) A patient who lacks decision-making capacity has executed, while competent, an advance directive specifying that specific treatment shall be withheld or withdrawn;

(d) A legally appointed "surrogate" exercising "substituted judgment" on behalf of a patient who lacks decision-making capacity requests that specific treatment be withheld or withdrawn. A legal guardian appointed in the State of Kansas may not direct the withdrawal or withholding of life-sustaining treatment, unless authorized by a written advance directive executed at a time when the patient was competent. A legal guardian appointed in the State of Missouri may consent to withdrawal or withholding of life-sustaining treatment if honoring prior (written) instructions from the patient, or if such authority is set forth in the court's order of appointment or letters of guardianship.

(e) One of the persons specified by VA regulations requests, on behalf of a patient who lacks decision-making capacity, the withholding or withdrawal of specific treatment.

(2) The specific procedures related to the limiting or withdrawing of therapy are subject to current VAEKHCS and VHA policies and are defined in directives.

c. Do Not Resuscitate (DNR)

When in the judgment of a treating physician, further medical intervention offers no overall medical benefit in prolonging the patient's life, the physician, after consultation with the patient who is competent, or in the case of a patient who is not competent, with the next of kin or surrogate as specified in VA regulations, may write an order not to resuscitate the patient (DNR). Legal guardians appointed in the State of Kansas may not direct the imposition of DNR, unless authorized by a written advance directive executed at a time when the patient was competent. Legal guardians appointed in the State of Missouri may consent to DNR only as outlined in the above paragraph on withdrawal of treatment, paragraph b. (1) (d). A progress note should be entered in the medical record, reflecting the discussion, the participants, and the wishes of the patient or the next of kin or surrogate decision-maker. A competent patient should be encouraged to complete a properly executed Advance Directive.

2. Restraint and Seclusion

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

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

3. Emergency or Involuntary Commitment

a. VAEKHCS will accept persons for emergency observation, detention, protective custody, and involuntary treatment under applicable state laws when appropriate beds are available.

b. If involuntary commitment of a patient for psychiatric/medical purposes is needed, the physician, following appropriate protocols, shall pursue legal action through the appropriate court to request such commitment.

c. Procedures for emergency, involuntary commitment will be in accordance with Kansas State laws and VA regulations and are outlined in VAEKHCS policy.

4. Electroconvulsive Therapy (ECT)

Electroconvulsive therapy will be used in accordance with VAEKHCS policy. The Medical Staff is responsible for ensuring that patients who are in need of electroconvulsive therapy are accorded the full protection available under law or regulation. Justification for electroconvulsive therapy will be fully documented in the patient's medical record.

H. ROLE OF ATTENDING STAFF

1. Resident Program

a. A report of significant discussions from the Medical School Resident faculty and the facility will be presented to the MEB and then to the Board of Directors.

b. Discussion may include items as success of board certifications, completion of residency, legal issues, etc.

2. Supervision of Residents

a. Resident physicians, dentists, podiatrists, optometrists and psychologists assigned to the VAEKHCS shall be provided appropriate supervision by Medical Staff members during their entire tour of duty. These rules apply to all patient care services including inpatient, outpatient, and Nursing Home settings, and the performance of all diagnostic and therapeutic procedures.

- b. Each Medical Staff member who is involved in teaching programs shall document his/her supervision in the medical record of assigned patients. Each Medical Staff member will also document his/her active participation in the care of the patients.
- c. Appropriate supervision includes examination of the patient, discussion of findings and therapeutic options, a plan for medical care, and documentation of those components of care.
- d. Medical Staff members who supervise residents are responsible for assuring that all diagnostic and therapeutic procedures, particularly invasive procedures, performed by residents on patients assigned to them are:
- (1) medically indicated;
 - (2) fully explained to the patient;
 - (3) properly executed;
 - (4) correctly interpreted; and
 - (5) evaluated for appropriateness, effectiveness and required follow-up. Evidence of this assurance will be documented in progress note(s) in the patient's medical record.
- e. Medical Staff shall indicate concurrence with proposed procedures and treatment plans and/or changes in the patient's level of care and document their concurrence with these proposed actions, documented, in the patient's medical record. Except in the instance of emergency situations, such concurrence must be obtained prior to initiating any major therapeutic or diagnostic procedure or significant revision in the patient's treatment plan. (An emergency is defined as a situation where immediate medical care is necessary to preserve the life or prevent serious impairment to the health of the patient. In such situations, any resident assisted by VAEKHCS personnel shall, consistent with informed consent provisions, be permitted to do everything possible to save the life of the patient.)
- f. Medical Staff members shall be familiar with each patient for whom they are responsible and must enter periodic notes in the patient's medical records verifying concurrence with diagnosis and treatment. The frequency of such notes shall be determined by the nature of the patient's condition, the likelihood of changes in the treatment plan, and the complexity of the care and the experience of the resident being supervised.
- g. Patient care orders in support of the agreed-upon treatment plan may be written by either the resident or the supervising Medical Staff member.
- h. Throughout all working hours of an outpatient clinic, there shall be available a Medical Staff member who is credentialed and privileged in the discipline represented by the clinic.

- i. The responsible attending Medical Staff member shall:
 - (1) Countersign in full signature the H&P; and
 - (2) Countersign all discharge summaries.
 - (3) Supervision
 - (4) Meeting with Medical School
 - (5) Report annually to Board of Directors on successful board certifications, number of completed Residency program, legal issues, etc.
 - j. Regarding the writing of orders for restraint and/or seclusion, these guidelines are established: Resident physicians are licensed physicians practicing under the supervision of identified attending physicians in VAEKHCS; therefore, resident physicians are permitted to write orders for restraint and/or seclusion consistent with VAEKHCS policy on restraint and seclusion. Such orders need to be in compliance with VAEKHCS policy before they are carried out by nursing or other staff. All such orders by resident physicians shall be reviewed by the attending physician, as required by VHA policy and these *Bylaws and Rules*. Any unlicensed or less than fully licensed resident physician shall not be permitted to write orders for restraint or seclusion.
 - k. All other trainees, such as physician assistant, nurse practitioner, or registered nurse anesthetist students, under the supervision of a Medical Staff member, shall be required to have countersignature on all H&Ps, orders, and progress notes, as well as appropriate supervision for all aspects of the trainee's clinical experience while at the VAEKHCS.
3. Supervision of Mid-level Practitioners
- a. In the VAEKHCS, mid-level practitioners serve in an interdependent role as a member of a physician-directed health care team, and each individual practices within his/her approved scope of practice. In these roles, each individual will have a VAEKHCS Medical Staff physician and an alternate physician who serve as supervisors or preceptors for the individual's practice.
 - (1) As described in other provisions in these *Bylaws and Rules of the Medical Staff*, the mid-level practitioners herein listed are Category IV members of the Medical Staff and are subject to the same credentialing and privileging processes as physician, dentist, podiatrist, and optometrist members of the Medical Staff. The practice of mid-level practitioners shall be governed by the scope of practice and prescriptive authority granted by a PSB to each individual, based on qualifications and current competence.

(2) Each mid-level practitioner will function within an individual scope of practice, including prescriptive authority if permitted by the practitioner's qualifications, developed by the individual practitioner and the assigned physician supervisors. The scope of practice shall be approved by the Director, upon recommendation of the SLM and the PSB. The scope of practice/prescriptive authority documents shall be updated and submitted for re-approval at least every two (2) years. The MEB has the authority and responsibility for developing and implementing appropriate guidelines for the employment and utilization of practitioners in medical care extender roles, consistent with VHA regulation and policy.

(3) Although each individual practitioner shall have a specifically identified physician supervisor, day-to-day clinical supervision may be provided by any qualified member of the Medical Staff.

(4) For inpatient admissions, supervising physicians shall enter an admission note into the medical record of each patient assigned to a mid-level professional. If the individual is not authorized by his/her scope of practice to independently perform H&P, the supervising physician shall co-sign the H&P.

(5) Periodic progress notes detailing the progress of care and the plan for future care will be entered by the supervising physician.

(6) Orders written by the mid-level practitioner within the prescriptive authority granted in the individual's scope of practice will not require countersignature by the supervising physician. All orders written outside the prescriptive authority of the individual's scope of practice will require countersignature by the supervising physician.

(7) Supervising physicians shall sign any discharge summary dictated by the mid-level practitioner.

(8) Each SLM will evaluate the quality and appropriateness of the care rendered by mid-level practitioners, including their compliance with scope of practice and prescriptive authority requirements. Such evaluation shall occur at least annually, in addition to the usual performance appraisal, and shall be a part of a systematic program of peer review/quality management/performance improvement.

b. A Medical Staff physician shall be available for immediate consultation via telephone at all times when a mid-level practitioner is performing non-routine/non-emergency duties as a part of his/her scope of practice.

I. MEDICAL RECORDS

1. General Requirements

- a. An adequate medical record shall be maintained for every patient, whether an inpatient, outpatient or emergency patient. The purposes of the medical record are:
 - (1) To furnish documentary evidence of the patient's illness, treatment given, course and response to treatment and final disposition;
 - (2) To serve as a basis for planning and for continuity of patient care;
 - (3) To provide a means of communication between the physicians and any other professionals who contribute to the patient's care;
 - (4) To serve as a basis for review, study and evaluation of the care rendered to the patient;
 - (5) To serve as a medico-legal document protecting the legal rights of the patient, treatment staff and the VA; and
 - (6) To provide data for use in research and education.
- b. All significant clinical information pertaining to a patient shall be incorporated in the patient's medical record. The record should be sufficiently detailed to enable:
 - (1) All providers to give effective continuing care to the patient, as well as to determine what the patient's condition was at a specific time and what procedures were performed;
 - (2) A consultant to give an opinion after his/her examination of the patient and the patient's medical record; and,
 - (3) All providers to know what has transpired in the management of the patient, and to know the patient's response to treatment.
- c. Medical records are the property of the VA.
 - (1) Information from the medical records will only be released in accordance with the Freedom of Information Act and the Privacy Act, as implemented by VA and the VAEKHCS.
 - (2) Medical records may be removed from the jurisdiction of the VAEKHCS and safekeeping only by a court order, subpoena, or statute, in accordance with VA regulations.
- d. Medical records will be created and maintained following the format approved by the VA.

- e. All entries in the record shall be made by individuals authorized to do so, and shall be legible, dated and authenticated, with a method to identify the author.
- f. On each visit of the patient, including each readmission, the responsible health care provider will make all previous medical records available for use.
- g. Medical Staff members and other health care providers who fail to complete their assigned responsibilities relating to the medical records may be subject to disciplinary actions in accordance with VA Handbook 5021.

2. Requirements for All Medical Records

- a. The medical record shall contain sufficient information to identify the patient and the provider clearly, to justify the diagnosis, to delineate the treatment plan and to document the results accurately. All medical records shall contain:
 - (1) Patient identification data, including identification number, either the Social Security number of the patient or a pseudo-social security number.
 - (2) Clear identification of the discipline/profession of the writer, i.e. M.D., D.O., D.D.S., D.P.M., P.A., R.N., A.R.N.P. (for Nurse Practitioner) etc., as well as a legible signature.
 - (3) A medical history, including known allergies, and a history of the present illness or injury.
 - (4) Progress notes giving a pertinent chronological report of clinical observations including the results of any therapy provided.
 - (5) Diagnostic and therapeutic orders (in accordance with Rule D, Medical Staff Orders, of these Rules).
 - (6) Authenticated reports of all procedures, laboratory, radiology and other tests and results.
 - (7) An informed consent document, executed prior to procedures and/or treatments (as prescribed in Rule E, Informed Consent, of these Rules).
 - (8) Disposition of the patient, including diagnosis and/or impression.
 - (9) Reports of all consultations ordered, containing an opinion by the consultant that reflects, where appropriate, an actual examination of the patient and review of the patient's medical records.

(10) Comprehensive operative reports are dictated, or written in the medical record, immediately after surgery is completed. Pre-operative and post-operative progress notes may be entered by the physician or other qualified individuals (such as resident physician trainees, PAs, NPs), when such responsibilities are defined in the individual's scope of practice and then must be authenticated by the surgeon. A progress note will be recorded for all diagnostic and therapeutic procedures not performed in the operating room, and such notes will contain: the name and date of the procedure, indications for the procedure, findings with description of the procedure and specimens removed, complications (if any), and patient condition. There shall be complete documentation by the surgeon in any case in which cadaver organs or tissues are removed for donation.

(11) Records of patients provided care and/or treatment under anesthesia will contain:

- (a) An evaluation of the patient's capacity to undergo anesthesia;
- (b) A pre-operative re-evaluation of the patient;
- (c) Intra-operative documentation of patient monitoring;
- (d) Post-operative status of the patient upon admission to and discharge from the Recovery Room; and
- (e) Documentation that the patient met the approved discharge criteria for discharge from the Recovery Room, or in the case of ambulatory surgery, from the facility.

3. Inpatient Records

Medical Records for patients admitted to the VAEKHCS will contain, in addition to contents described in paragraph 2, above, these elements:

a. H&P

An H&P that includes present and past medical history, family, and social history to include military (if not previously documented) and occupational history, and inventory of body systems. A present and past medical history, physical examination, system review and initial plan of care including provisional diagnoses shall be performed and documented by a physician within 24 hours of admission of the patient to an inpatient unit. In Psychiatry, this will include a psychiatric history. If it is anticipated that a dictated H&P may not be incorporated into the medical record within 24 hours of a patient's admission, then a progress note containing pertinent information and findings to enable clinicians to manage the patient and guide the plan of care should be placed in the medical record within the first 24 hours of a patient's admission.

- b. In the Community Living Center (CLC) or other units surveyed for accreditation under the JC Long Term Care standards, the history and physical examination will be performed and documented in the medical record within 72 hours of admission of the patient.
- c. In those instances when a patient is readmitted within 30 days following the date of the latest prior complete H&P (performed on an inpatient or outpatient basis), an interval H&P reflecting any subsequent changes may be used in the medical record. An interval H&P, when used, will be entered in a progress note and will contain the following:
- (1) A statement that the previous H&P has been reviewed;
 - (2) A statement that there are pertinent additions to the history/and or subsequent changes in the physical findings which will be specified;
 - (3) A statement indicating there is no change noted in the review of the previous H&P.
- This is permitted if it is medically determined that such an exam, in conjunction with the prior exam, is adequate to reflect a comprehensive and current physical examination. In all cases where surgery is performed, the medical record will show documentation of a complete H&P performed within the past 30 days, or an interval H&P exam progress note, as described above. This documentation must be in the medical record prior to the surgical operation or procedure. In an emergency, when there is no time to record the complete H&P, a note on the preoperative diagnosis is recorded before surgery.
- d. Readmission on or after the 31st day after the date of the most recent prior H&P will require completion of a current H&P.
- e. An admission progress note including a statement of the conclusions and/or impressions resulting from the H&P along with a planned course of action while the patient is hospitalized. This is not required when an H&P is done at the time of admission and documented in the medical record.
- f. For a psychiatric case, a psychiatric evaluation, including psychological testing, as indicated.
- g. In Extended Care and the Community Living Center (CLC) settings, assessments will be completed within the time frames specified by the JC, and updates accomplished accordingly.
- h. A comprehensive treatment plan.
- i. Progress notes recorded at a frequency appropriate to the condition of the patient on medical/surgical patients; specifically, a stable patient should have notes recorded three (3) times per week and patients in ICU should have notes written daily or more often, as appropriate, based on the condition of the patient. Progress notes on acute psychiatry patients

should be written at least weekly. Long-term care patients should have progress notes at least monthly. All entries in the progress notes should contain pertinent, meaningful observations and information. These notes must be dated, timed and signed, giving the status (professional designation) of the health care professional writing the note.

j. Final summary and diagnosis.

Final summaries shall be prepared at the termination of each period of hospitalization, or as may otherwise be required. The summary must be dictated promptly after the discharge of the patient. The summary must include:

- (4) The final diagnosis(es) recorded in full, without the use of symbols or abbreviations;
 - (5) All operations and/or procedures performed;
 - (6) A concise recapitulation of the reason for admission, significant findings and treatment rendered;
 - (7) The condition of the patient at discharge, stated in measurable terms;
 - (8) The date the patient is capable of returning to employment or pre-hospital activity;
 - (9) Period of convalescence, if required;
 - (10) Recommendations for follow-up treatment;
 - (11) Medications given; and
 - (12) An opinion, as indicated, as to competency to handle funds when indicated.
- k. No inpatient medical record shall be declared complete for purposes of filing until the record is deemed complete and the responsible physician has reviewed and signed the hospital summary.

(13) Any deficiency in the medical record that is discovered after the patient has been discharged will be returned to the appropriate Medical Staff member for correction.

(14) Delinquent Records

A medical record is considered to be delinquent if it is not complete for purpose of filing within thirty (30) calendar days of the patient's discharge.

(15) Autopsy

When an autopsy is performed, provisional anatomic diagnosis (es) will be recorded within seventy-two (72) hours. Final necropsy protocols must be made part of the patient's medical record with thirty (30) working days, or within three (3) months in complicated cases.

4. Records of Outpatient Care

Outpatient medical records will contain, in addition to contents delineated in paragraph 2, above:

- a. Vital signs as a part of the H&P findings.
- b. Medication and problem lists which include:
 - (1) Known significant medical diagnoses and conditions;
 - (2) Known significant surgical and invasive procedures;
 - (3) Known adverse and allergic reactions to drugs; and
 - (4) Medications known to be prescribed for and/or used by the patient.
- c. Updates to all required information on each patient visit.
- d. If a patient is in group therapy, a progress note should be written at least once a month. Each progress note should specify the dates the patient attended since his/her last progress note, and each listed goal should relate to the initial patient assessment and treatment plan.
- e. Annual assessment

After one year of outpatient care, patients not enrolled in Medicine will have an assessment annually. The assessment should include a physical and/or mental examination, as appropriate. Diagnoses treated and those requiring further care will be recorded in the medical record. The annual assessment will be clearly labeled as such in the medical record.
- f. When the patient is released or discharged from any clinic (which involved more than one visit), a final note will be recorded, content of which will include:
 - (1) Summary of care provided;
 - (2) Diagnoses for which treatment was provided, and the procedures performed;
 - (3) Significant findings and patient condition at discharge;
 - (4) Medications provided, diet, and physical activity limitations; and

(5) Education provided at level of patient understanding.

J. INFECTION CONTROL

1. The Chairperson of the Infection Control Committee has the authority to initiate corrective action or other appropriate action to correct identified deficiencies when there is a potential danger to patients and/or personnel.
2. The Medical Staff shall actively participate in the development and administration of effective measures to prevent, identify and control hospital associated infections and infection potentials.
3. Medical Staff members will also:
 - a. Participate on and/or cooperate with the Infection Control Committee;
 - b. Report communicable disease as required by the Kansas State Department of Health and VA policy;
 - c. Ensure compliance with OSHA standards, including those related to universal precautions.

K. EMERGENCY PREPAREDNESS

Medical Staff members will become familiar with and participate in the development of the facility Emergency Preparedness Plan. They will participate, as determined by such a plan and by VA, in any actual disasters and in the VA/DOD Contingency Plan.

L. MEDICAL STAFF HEALTH AND IMPAIRMENT

1. VAEKHCS has an obligation to protect patients from harm. At the same time, VAEKHCS values Medical Staff members and their health. For these reasons, VAEKHCS has a process separate from the disciplinary process to identify and manage matters of individual Medical Staff member health and impairment. The process includes education about Medical Staff health issues, including physical, psychiatric or emotional illness. Further, the process fosters reporting of Medical Staff illness with the potential to endanger patients, and facilitates the confidential diagnosis, treatment and rehabilitation of Medical Staff who suffer from impairing conditions.
2. To the greatest extent possible, the purpose of the process is assistance and rehabilitation, rather than discipline of Medical Staff. The goal is to retain or regain optimal professional functioning consistent with the protection of patients.

3. When a member of the Medical Staff suffers physical, mental or emotional impairment that jeopardizes professional practice, clinical competence and/or patient care, including but not limited to drug or alcohol abuse, the Chief of Staff may recommend temporary reassignment to non-patient care duty and may propose suspension of clinical privileges. In such a case, strict attention will be given to procedural requirements and due process rights as provided in federal law/regulation and VA policy, including the fair hearing and appellate rights outlined in these *Bylaws and Rules*. Additionally, there will be proper adherence to requirements for reporting adverse actions to state licensing boards and to the NPDB.

4. The process includes these features:

a. Education of Medical Staff (and other staff) about issues of illness and impairment, and about recognition of such problems specific to medical staff, will be carried out periodically through the CME programs of VAEKHCS.

b. VAEKHCS has Employee Assistance Programs (EAP) available to members of the Medical Staff and all other employees. These programs assist in the initial recognition, diagnosis and treatment of physical, psychiatric or emotional problems, including drug or alcohol abuse, that have detrimental effects on the performance of professional duties. A Medical Staff member may self-refer to EAP. Supervisory/management personnel may recommend the EAP to Medical Staff members. Additionally, a Medical Staff member may contact the Employee Health Physician, or may seek help from health care sources outside the VAEKHCS.

c. Confidentiality and privacy of the Medical Staff member seeking referral (or referred for assistance) to any of these sources shall be maintained, except as limited by law or ethical obligation. When the safety of a patient is threatened, those with a need to know shall be appropriately informed.

d. Any instance in which a Medical Staff member provides unsafe treatment to a patient must be reported to the Chief of Staff, either directly or through supervisory channels. The Chief of Staff and Director are responsible for evaluating the credibility of a complaint, allegation or concern.

e. The professional performance of the affected Medical Staff member will be monitored, as will the safety of patients under his/her care, until rehabilitation or any disciplinary action is complete.

f. The responsibility of VAEKHCS for recommending treatment and assisting the impaired Medical Staff member with referral for treatment is important, and will be accomplished to the extent possible.

g. When necessary, the Chief of Staff may utilize the procedures outlined in VHA policy for the initiation of a Physical Standards Board to determine a Medical Staff member's fitness for duty. All VA Manual regulations for the conduct of a Physical Standards Board, including due process rights, will be strictly followed.

M. CLOSURE

VA Eastern Kansas Health Care System policies must not be in conflict with the *Bylaws and Rules of the Medical Staff* of the VAEKHCS. VAEKHCS policies are considered an extension of the *Bylaws and Rules*. They are available to all staff directly, through SLM, or from the office of the Chief of Staff. They are available to prospective staff for review upon request. Any request for changes to the Rules should be referred back to Article XII, Amendments of the *Bylaws*.