

DEPARTMENT OF VETERANS AFFAIRS  
VA Pittsburgh Healthcare System  
Pittsburgh, PA 15240

Memorandum MS-004

December 2010

**BYLAWS AND RULES OF THE MEDICAL STAFF  
OF  
VETERANS HEALTH ADMINISTRATION (VHA)  
  
VA PITTSBURGH HEALTHCARE SYSTEM  
PITTSBURGH, PENNSYLVANIA**

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**PREAMBLE \***

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

VA Pittsburgh Healthcare System serves a Veteran population of over 59,000 throughout the tri-state area of western Pennsylvania, Ohio, West Virginia and counties in Maryland. The VAPHS consists of three separate geographic facilities operating under one management.

The University Drive Division, located in the Oakland section of the City of Pittsburgh, is a tertiary level medical/surgical facility with 146 staffed beds. It serves as a referral center for many specialty programs, including but not limited to liver and kidney transplant, cardiac surgery, bariatric surgery, neurosurgery, invasive cardiology, oncology, and radiation therapy, specialized services include robotics in cardiology and urology, audiology and speech pathology, dermatology, optometry/ophthalmology, arrhythmia and arthritis, diabetes management, endocrinology, gastroenterology, nephrology, pain management and primary care. National Centers of Clinical Excellence include the Women Veterans Health and Renal Dialysis.

The Highland Drive Division, located in the Highland Park section of the City of Pittsburgh, has 79 staffed behavioral health beds and provides a variety of outpatient clinics, research programs and support services. The Outpatient programs include the Center for Treatment of Addictive Disorders, the Post-Traumatic Stress Disorder clinic, Operation Enduring Freedom/Operation Iraqi Freedom clinic, and a Regional Center for Treatment of Former Prisoners of War. Other outpatient services include dental, orthotics, primary care, compensated work therapy, audiology and speech pathology, physical therapy, and Adult Day Health Care. Specialized research programs include the following four National Research Centers of Excellence, Center for Health Research Equity and Promotion, Geriatric Research, Education and Clinical Center, Human Engineering Research Laboratories, and Mental Illness Research, Education and Clinical Center.

The H. John Heinz Progressive Care Division, located in O'Hara Township near the town of Aspinwall, is comprised of the Community Living Center (CLC), with 215 staffed beds, comprehensive homeless program, residential rehabilitation, dental and primary care. The primary care clinics serves our only Spinal Cord Injury clinic ( SCI ) , as well as Podiatry, Optometry, Neurology, Polytrauma, TBI, EMG testing, Anti-coagulation

clinic, Clinical dietician services, Psychiatry and Psychology clinics serving approximately 5,600 veterans. The CLC is supported by many specialties including transitional care, rehabilitation, respite care, palliative/hospice care, dementia care, and speech pathology.

The VAPHS has five community-based outpatient clinics in St. Clairsville, Ohio; Aliquippa, Washington, Greensburg, and Uniontown in Pennsylvania that provide primary care services for Veterans in their local area.

The VAPHS serves as a teaching facility through affiliations with the University of Pittsburgh School of Medicine and other highly respected educational institutions and actively supports Veterans Health Administration's research and education missions.

The mission of VA Pittsburgh Healthcare System is to honor America's Veterans with world-class health care, train their future providers and advance medical knowledge through research.

The shared vision is to partner with Veterans and their families to optimize their health and quality of life through integrated, innovative and compassionate care.

## DEFINITIONS

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

1. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, Mid-level and/or patient care services at the facility. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.
2. Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when serving in the capacity of Acting Facility Director.
3. Associated Health Professional: As used in this document, the term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine. These professionals include, but are not limited to: Pharmacists (PharmDs), psychologists, podiatrists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.
4. Automatic Suspension of Privileges: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Medical Executive Board.
5. Chief of Staff: The Chief of Staff is the President of the medical staff and Chairperson of the Medical Executive Board and acts as full assistant to the Director

in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioners, Mid-level Practitioners, and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of medical staff.

6. Clinical Privileges: Clinical Privileges is the authority granted by the Director to a licensed independent practitioner to provide specific patient care services, in the healthcare system. Clinical privileges are provider-specific within well-defined limits, based on the individual practitioner's professional license, education, training, experience, competence, health status, and judgment.
7. Clinical privileging: Clinical privileging is the process by which a practitioner, licensed for independent practice (e.g. without supervision, direction, required sponsor, preceptor, mandatory collaboration) is permitted by law and the healthcare system to practice independently, to provide 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, competence, provider specific data, judgment, health status, education, training and licensure. Medical staff who have no direct patient contact, do not provide any inpatient or outpatient care or consultation, and have no access to patient records are exempt from clinical privileging but must be credentialed.
8. Community Based Outpatient Clinic (CBOC): A health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional medical staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients. A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures
9. Competencies: General competencies of the Medical Staff as developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) include patient care; medical/clinical knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism, and systemic-based practice.
10. Continuing Medical Education (CME): Continuing Medical Education activities serve to maintain, develop, or increase knowledge, skills, and professional performance and relationships that a practitioner uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skill generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.
11. Credentialing: Credentialing involves the collection, verification and analysis of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the

requested privilege(s). Verification is sought to minimize the responsibility of granting privilege(s) based on the review of fraudulent documents.

12. Credentialing and Privileging: Credentialing and Privileging involves a series of activities designed to verify and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.
13. Director (or Facility Director): The Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS), and the Medical Executive Board.
14. Focused professional practice evaluation: Focused professional practice evaluation is designed to monitor one or more aspects of a practitioner's performance. A focused professional practice evaluation will be conducted on all new providers who are starting employment, when a provider requests new clinical privileges, and when issues affecting the provision of safe, high quality patient care are identified.
15. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the Facility Director. The Director is responsible for the oversight and delivery of health care by all employees and specifically including the medical staff credentialed and privileged by the relevant administrative offices and facility approved processes.
16. Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the VA Pittsburgh Healthcare System to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians, dentists, podiatrists, optometrists, psychologists, social workers, audiologists or speech pathologists.
17. Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the medical staff process that are subject to the medical staff bylaws. This body may include others, such as retired Practitioners who no longer practice in the organization but wish to continue their membership in the body. The medical staff includes both members of the organized medical staff and non-members of the organized medical staff who provide health care services.
18. Mid-Level Practitioner: Mid-Level Practitioners are those health care professionals who are not physicians and dentists and who, most often, function within a Scope of Practice but may practice autonomously on defined clinical privileges as defined in these Bylaws. Mid-Level Practitioners include: physician assistants (PA), and

advanced practice nurses (ARNP, CRNA, and CRNP). Mid-Level Practitioners may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations, under the supervision of a credentialed and privileged Licensed Independent Practitioner when required. Mid-Level Practitioners do not have admitting privileges and may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations. Advanced Registered Nurse Practitioners and other health care professionals may be granted defined clinical privileges when allowed by law and the facility (this is a facility decision).

19. The National Practitioner Data Bank (NPDB): The NPDB is a secondary source of information that will report only those malpractice reports made in behalf of the practitioner and reportable formal disciplinary actions taken by reporting medical licensing and disciplinary boards, professional societies, and health care facilities.
20. Nurse Executive (Associate Director, Patient Care Services): The Nurse Executive is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he is the Chairperson of the Nurse Executive Counsel (NEC) and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant mid-level and certain allied health staff and in ensuring the ongoing education of the nursing staff.
21. Ongoing professional practice evaluation: Ongoing professional practice evaluation will be conducted on an annual basis and is designed to evaluate a practitioner's performance over a period of time. The process allows any potential problems with a practitioner's performance to be identified and resolved as soon as possible, and fosters a more efficient, evidence-based privilege renewal process.
22. Organized Medical Staff: The body of Licensed Independent Practitioners who are collectively responsible for adopting and amending medical staff bylaws (i.e., those with voting privileges) and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges.
23. Outpatient Clinic: An outpatient clinic is a healthcare site where the medical or psychiatric care is not inpatient care.
24. Peer: A peer is a practitioner of similar education, training, licensure, and clinical privileges or scope of practice, which is deemed capable of assessing the performance, judgment and clinical skills of another health care provider.
25. Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner-specific data collected from various sources for the purpose of evaluating current competence.
26. Primary Source Verification: Documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health



care Practitioner. This can be a letter, documented telephone contact, or secure electronic communication with the original source.

27. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.
28. Professional Standards Board: The Professional Standards Board, if established, may act as a Credentials Committee on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matter to the Executive Committee of the Medical Staff as defined in these Bylaws. This board also may act on matters involving Allied Health and Mid-Level Practitioners such as granting prescriptive authority, scope of practice, and appointment. Some professional standards boards (e.g. Nursing, etc) are responsible for advancement and other issues related to their respective professions.
29. Recredentialing: Recredentialing is an evaluation process of the professional credentials and clinical competence of the medical staff that have been granted clinical privileges. The process is conducted every two years.
30. Rules: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the bylaws. They can be reviewed and revised by the Medical Executive Board and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.
31. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider.
32. Telemedicine: The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.
33. VA Regulations: The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws. (Example: Code of Federal Regulation (CFR) 38 7402)
34. VetPro: VetPro is an internet enabled system for the credentialing of VHA health care providers that facilitates completion of a uniform, accurate, and complete credentials file and has sharing capabilities throughout the national VA HealthCare System.

**ARTICLE I. NAME**

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, VA Pittsburgh Healthcare System.

**ARTICLE II. PURPOSE**

The purposes of the Medical Staff shall be to:

1. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care, regardless of the practitioner, service or location of the health care system. Primary care programs will assure continuity of care and minimize institutional care.
3. Establish and assure adherence to ethical standards of professional practice and conduct, including maintenance of confidentiality of patient care.
4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: care provided, findings of quality of care review activities, advances in medical science, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of Practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.
8. Provide a medical perspective, as appropriate, to issues being considered by the Director and Governing Body.
9. Develop and implement performance and safety improvement activities in collaboration with the Executive Leadership Board and assume a leadership role in improving organizational performance and patient safety.
10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved including patient safety and patient satisfaction.
11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
12. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.
13. Cooperate with the affiliated medical school and other educational institutions for undergraduate, graduate, post-graduate and continuing education in medicine and

related sciences, and encourage participation of staff members in basic clinical research.

14. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational publications.
15. Coordinate and supervise the scope of practice of all Mid-Level and appropriate Allied Health Practitioner staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each Mid-Level and appropriate Allied Health Practitioner should have a scope of practice statement or privileges as well as the means employed to coordinate and supervise their function with the medical staff.
16. Serves as the primary means for accountability to the Director through the Chief of Staff for the quality of patient care, the professional performance and ethical conduct of its members and strive toward the continual upgrading of the quality of patient care delivered in the healthcare system consistent with the state of the healing arts and resources locally available.
17. Serves as a patient advocate.
18. Advises the governing body of resources needed to optimize patient care.
19. Recommend the clinical services to be provided by telemedicine.

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

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

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, dentists, podiatrists, optometrists, psychologists, social workers, audiologists, and speech pathologists who continuously meet the qualifications, standards, and requirements of VHA, this Facility, and these Bylaws.
2. Categories of the Medical Staff:
  - a. Active Medical Staff: The active Medical Staff shall consist of all full-time and part-time physicians, dentists, podiatrists, optometrists, psychologists, social workers, audiologists, and speech pathologists, who are professionally responsible for specific patient care and/or education and/or research activities in the healthcare system and who assume all the functions and responsibilities of membership on the active staff. Members of the active medical staff shall be appointed to a specific service line, shall be eligible to vote and to serve on medical staff committees and shall be required to attend medical staff meetings.
  - b. Associate Medical Staff: The associate Medical Staff shall consist of physicians, dentists, podiatrists, optometrists, psychologists, social workers, audiologists, and speech pathologists, who are on consulting, attending, on-station fee basis, contract, or without compensation appointment and are responsible for supplementing the practice of members of the active staff in their roles in

education, patient care and/or research. Consultants will be those individuals who have recognized professional ability and experience of professorial rank. Both consultants and attendings will be appointed to a specific service line. Neither fee basis, (except contract staffs that are program leaders), staff appointed without compensation, or consultant and attending staff shall be required to attend meetings of the medical staff. Associate Medical Staff are not eligible to vote.

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

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

1. Criteria for Clinical Privileges: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial:
  - a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required by VA employment and utilization policies and procedures.
  - b. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine, Osteopathy, Dentistry, Optometry or Podiatry from an approved college or university. Other licensed independent practitioners on the medical staff (psychologists, social workers, audiologists, speech pathologists) must meet the educational requirements as defined in VA regulations.
  - c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training.
  - d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying.
  - e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.
  - f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VI or VII or of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff.
  - g. Satisfactory findings relative to previous professional competence and professional conduct.

- h. English language proficiency.
  - i. Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.
  - j. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver's license or passport) to verify identity.
2. Clinical Privileges and Scope of Practice: While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent Practitioners are permitted by this Facility and these Bylaws to practice independently. All Practitioners listed below are subject to the bylaws whether they are granted defined clinical privileges or not.
- a. The following Practitioners will be credentialed and privileged to practice independently:
    - i) Physicians
    - ii) Dentists
  - b. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:
    - i) Clinical Social Workers
    - ii) Doctors of Pharmacy
    - iii) Clinical Pharmacists
    - iv) Psychologists
    - v) Audiologists
    - vi) Speech Pathologists
    - vii) Podiatrists
    - viii) Optometrists
    - ix) Chiropractors
  - c. The following Practitioners will be credentialed and will practice under a Scope of Practice with appropriate supervision:
    - i) Physician Assistants.
    - ii) Advanced Practice Nurses
    - iii) Clinical Pharmacists
    - iv) Clinical Nutrition Specialists (Registered Dieticians)
3. Change in Status: Members of the Medical Staff as well as all Practitioners practicing through privileges or a scope of practice must agree to provide care to patients within the scope of their Delineated Clinical Privileges or Scope of Practice

and advise the Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges which are held, and any changes in the status of professional credentials, such as, but not limited to, loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society as soon as able, but no longer than 15 days after notification of the practitioner.

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

1. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being on duty as scheduled. (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.
2. Disruptive Behavior and Inappropriate Behavior: VA recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. VA strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact.

Disruptive behavior is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff,

patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, disruptive behavior may reach a threshold such that it constitutes grounds for further inquiry by the Medical Executive Committee into the potential underlying causes of such behavior. Behavior by a provider that is disruptive could be grounds for disciplinary action.

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

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

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

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

### **Section 4.01 Leaders \***

1. Composition:
  - a. Chief of Staff.
2. Qualifications: The Chief of Staff must be a physician who has had appropriate experience in medical practice, academic affairs, and administration. It is understood that any individual selected as Chief of Staff shall be a member of the Medical Staff and have privileges ex officio to act as a consultant in evaluating all aspects of patient care and other professional services provided by the facility.
3. Selection: The selection of a Chief of Staff begins with a Search Committee selected by the Director with the consent of the (VISN 4) Director. The Director should seek advice from the Dean of the University of Pittsburgh Medical School in selecting the Search Committee. The Search Committee shall determine a list of applicants for the position who warrant further evaluation. Each of these candidates should be interviewed by members of the Medical Executive Board and by the Search Committee. The Committee shall make recommendations to the VA Pittsburgh Healthcare System Director and the VISN 4 Director regarding acceptable candidates for the Chief of Staff along with an explanation of their perceived strengths and weaknesses. The VAPHS Director and VISN 4 Director

then select an individual from the candidates recommended by the Search Committee and provide information about that individual to the Management Support Office and the VA Professional Standards Board (VA Central Office). After Central Office has completed a technical review of the candidate, the VISN 4 Director then appoints the Chief of Staff on behalf of the Governing Body. The Chief of Staff may also apply for and be granted specific privileges to provide direct patient care. Tenure of the Chief of Staff is determined by the Governing Body, represented by the VISN 4 Director. Although the Chief of Staff is not an elected "officer," he/she may be removed through the processes described in MP-5 Part II, Chapters 6 (Proficiency Rating System), 8 (Disciplinary Actions), 9 (Separations), 10 (Physical Requirements), and VHA supplements hereto consistent with these bylaws. Proposed action to remove the Chief of Staff will be coordinated through the Director.

4. Duties:
  - a. Chief of Staff serves as Chairperson of the Medical Executive Board.
  - b. The Chief of Staff acts as the executive officer of the Medical Staff.
  - c. The Chief of Staff's office shall facilitate effective communication between the Medical Staff and the Director using written documents and appropriate meetings.
  - d. The Chief of Staff will represent the Medical Staff at regularly scheduled hospital administrative meetings and shall assure that the Medical Staff is appropriately represented in any hospital deliberation affecting the discharge of Medical staff responsibilities.
  - e. The Chief of Staff will also act as the main representative of the Medical Staff with respect to physician trainee issues.
5. Grounds for Removal: Ground for removal of the Chief of Staff or Members of the Medical Staff include, but are not limited to:
  - a. Failure to perform the duties of the position in a timely and appropriate manner;
  - b. Failure to satisfy continuously or significantly the justifications of the position;
  - c. Conviction of a felony;
  - d. Loss of professional licensure.

#### **Section 4.02 Leadership**

1. The Organized Medical Staff, through its committees and Service Line Vice Presidents, provides counsel and assistance to the Chief of Staff and Director regarding all facets of patient care, treatment, and services including evaluating and improving the quality and safety of patient care services, performance improvement, goals, plans, education, research, mission, and services offered and assists with prioritization of hospital sponsored continuing education. All active Medical Staff members are eligible for membership on the Medical Executive Board.



### Section 4.03 Clinical Services \*

1. Characteristics: \*
  - a. Clinical Services are organized to provide clinical care, research, teaching and treatment under leadership of a Vice President through the following Service Lines:
  - b. The following Service Lines provide patient care, research and teaching activities at this healthcare system under the leadership of the Service Line Vice President:
    - i) Primary Care Service Line:
      - Primary Care Clinics
      - Community Based Outpatient Clinics
      - Women's Health Program
      - OEF/OIF Clinic
    - ii) Behavioral Health Service Line:
      - Behavioral Health Clinics
      - Center for Treatment of Addictive Disorders
      - Patient Evaluation & Referral Center
      - Psychiatric Consults
      - Neuropsychiatry
      - TBI
      - Hospital Based Care
      - Specialty Outpatient Services
      - Domiciliary Care
      - Homeless Program
      - PRRTP PTSD
    - iii) Geriatrics & Extended Care Service Line:
      - Nursing Home Care Unit
      - Dementia Special Care Unit
      - Respite Care
      - Hospice and Palliative Care
      - Consultation/Specialty Clinics
      - Transitional Care
      - Medical coverage for the Southwestern Veterans Center
    - iv) Medical Specialty Service Line:
      - Specialty Clinics
      - Medical Consults
      - Inpatient Consults/Procedures
      - Special Case Primary Care
    - v) Surgical Specialty Service Line:
      - Specialty Clinics
      - Surgical Consults
      - Operating Room
      - Anesthesia
      - Recovery Room

- Sterile Processing
- Same Day Surgical Unit
- 23 Hour Observation
- vi) Critical Care Service Line:
  - Medical ICU
  - Surgical ICU
  - Coronary Care Unit
  - Step Down Unit
  - Respiratory Therapy
  - Emergent Care Center
- vii) Clinical Support Service Line:
  - Pathology & Laboratory Medicine
  - Pharmacy
  - Physical Medicine & Rehabilitation
  - Dental Medicine
  - Audiology & Speech Pathology
  - Prosthetics
- viii) Health Administration Service:
  - Call Center
  - Care Management
- ix) Imaging Services:
  - Radiology
  - Nuclear Medicine
  - Radiation Therapy/Oncology
- x) Research:
  - Research projects
  - Institutional Review Board
  - Research Centers of Excellence
- xi) Patient Care Services Line:
  - Nursing
  - Voluntary
  - Recreation
  - Telemetry
- xii) Community Based Care Service Line:
  - Community Support Program
  - Work Therapy
  - Home Based Primary Care
  - Community Health Nursing
  - Community Nursing Home Program
  - Domestic Relations
  - Visual Impairment Services
  - Adult Day Health Care

2. Functions: \*
  - a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety, (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; patient safety and risk management activities; and utilization management.
  - b. Assist in identification of important aspects of care for the Service, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities.
  - c. Maintain records of meetings that include reports of conclusions, data, recommendations, responsible person, actions taken, and an evaluation of effectiveness of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on a quarterly basis.
  - d. Develop criteria for recommending clinical privileges for members of the Service and ensure that ongoing professional practice evaluation is continuously performed and results are utilized at the time of re-privileging.
  - e. Define and/or develop clinical privilege statements including levels (or categories) of care that include all requirements of VHA Handbook 1100.19.
  - f. Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within the Service.
  - g. Annually review privilege templates for each Service and make recommendations to Medical Executive Board.
3. Selection and Appointment of Vice Presidents: \* Vice Presidents are appointed by the Director based upon the recommendation of the Chief of Staff and approved by the VISN and Central Office.
4. Duties and Responsibilities of Vice Presidents: \* The Vice President is administratively responsible for the operation of the Service and its clinical and research efforts, as appropriate. In addition to duties listed below, the Vice President is responsible for assuring the Service performs according to applicable VHA performance standards. These are the performance requirements applicable to the Service from the national performance contract, and cascade from the overarching requirements delegated to the Chief of the Medical Staff. These requirements are described in individual Performance Plans for each Vice President. Vice Presidents are responsible and accountable for:
  - a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as Service Line Vice President.
  - b. Clinically related activities of the Service.

- c. Administratively related activities of the department, unless otherwise provided by the organization.
- d. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges through FPPE/OPPE.
- e. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service.
- f. Recommending appointment and clinical privileges for each member of the Service. Service Line VP's must document their review of all licensed healthcare practitioners in VetPro on the Service Chief's approval screen and may delegate this responsibility only when another provider is covering in their absence.
- g. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the Service and communicating the recommendations to the relevant organizational authority.
- h. The integration of the Service into the primary functions of the organization.
- i. The coordination and integration of interdepartmental and intradepartmental services. This includes access, efficiency, effectiveness and appropriateness of care and treatment of patients served and the clinical/professional performance of all practitioners
- j. The development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.
- k. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.
- l. The determination of the qualifications and competence of service personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services.
- m. The continuous assessment and improvement of the quality of care, treatment, and services.
- n. The maintenance of and contribution to quality control programs, as appropriate.
- o. The orientation and continuing education of all persons in the service.
- p. The assurance of space and other resources necessary for the service defined to be provided for the patients served.
- q. Annual review of all clinical privilege forms to ensure that they correctly and adequately reflect the services being provided at the facility. This review is noted by date of review being included on the bottom of each privilege delineation form.
- r. Assesses and recommends to the Chief of Staff off-site sources for needed patient care, treatment, and services not provided by the Service Line or healthcare system.
- s. Addressing any request made by a staff member not to participate in an aspect of care due to conflicts with the staff member's cultural values, ethics, and/or religious beliefs and assuring continuity of appropriate patient care in such cases.

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

### **Section 5.01 General**

1. Committees are either standing or special.
2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.
3. The presence of a minimum of twenty-five (25) percent of a committee's members will constitute a quorum.
4. The members of all standing committees, other than the Medical Executive Board, are appointed by the Chief of Staff subject to approval by the Medical Executive Board, unless otherwise stated in these Bylaws.
5. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff.
6. Robert's Rules of Order will govern all committee meetings.

### **Section 5.02 Executive Committee of the Medical Staff \***

1. Characteristics: The Medical Executive Board serves as the Executive Committee of the Medical Staff. The members of the Medical Executive Board are:
  - a. Chief of Staff, Chairperson, voting.
  - b. Clinical Service Line Vice Presidents, voting.
  - c. Practitioners appointed through the medical staff process, voting.
  - d. Director, or designee, ex-officio, non-voting. \*
  - e. Nurse Executive, ex-officio, non-voting
  - f. ACOS/Research
  - g. Chairperson, Adverse Event and Procedure Review Committee
  - h. Member at Large (will rotate every year - appointed by vote of the Medical Staff)
  - i. Other facility staff as may be called upon to serve as resources or attend committee meetings at the request of the chairperson, with or without vote. For example, a Physician Assistant may be called to be present when an action affecting another Physician Assistant is being considered. Any member of the Medical Staff (with or without vote) is eligible for consideration.
  - j. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
2. Functions of the Medical Executive Board The Medical Executive Board: \*
  - a. Acts on behalf of the Medical Staff between Medical Staff meetings.
  - b. The Medical Executive Board will serve as the Professional Standards Board. It will act on appointments, promotions, special advancements, probationary

reviews, fitness for duty assessments, suspension, termination and other professional actions in regard to the credentialing and privileging of the Medical Staff to ensure that the healthcare system recruits and retains the best-qualified medical staff. When there is doubt about an applicant's ability to perform the privileges requested, the Board may request a more definitive evaluation of the provider's practice.

- c. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process in support of clinical privileges and/or scope of practice requested; to address the scope and quality of services provided within the facility.
- d. Acts to ensure effective communications between the Medical Staff and the Director.
- e. Makes recommendations directly to the Director regarding the:
  - i) Organization, membership, structure, and function of the Medical Staff.
  - ii) Process used to review credentials and delineate privileges for the medical staff.
  - iii) Delineation of privileges for each Practitioner credentialed.
  - iv) Development, adoption, amendment and enforcement of the medical staff bylaws, rules, regulations and policies.
  - v) Mechanisms by which medical staff membership may be terminated;
  - vi) Mechanisms for fair hearing procedures;
  - vii) Participation of the medical staff in organizational performance improvement activities; as well as the mechanism to conduct, evaluate, and revise such activities;
  - viii) Ethical and self-governance actions of the medical staff;
  - ix) Corrective action for practitioner-specific issues and systems issues that are identified during the peer review process.
  - x) Recommendations for new on-site clinical services and services provided by telemedicine.
- f. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.
- g. Oversees process in place for instances of "for-cause" concerning a medical staff member's competency to perform requested privileges.
- h. Oversees process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.
- i. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.
- j. Monitors medical staff ethics and self-governance actions.

- k. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.
- l. Receives and acts on reports and recommendations from medical staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body.
- m. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.
- n. Acts upon recommendations from the Credentialing and Privileging Department.
- o. Acts as and carries out the function of the Physical Standards Board, which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician. The Physical Standards Board may have the same membership as the local physician Professional Standards Board or members may be designated for this purpose by the health care facility Director. Boards may be conducted at other VA healthcare facilities.
- p. Provides oversight and guidance for fee basis/contractual services.
- q. Annually reviews and makes recommendations for approval of the Service-specific privilege lists.
- r. Establish guidelines to standardize peer review across the VAPHS and will evaluate medical care according to currently recognized community standards and/or practices including, but not limited to Clinical Practice Guidelines, Performance Measures, and InterQual Criteria.
  - i) The Medical Executive Board will recommend to the Executive Leadership Board/Director appropriate corrective action for practitioner-specific issues (i.e. adverse privileging decisions) and systems issues that are identified during the peer review process.
  - ii) Aggregate data on peer review outcomes and any repetitive trends or patterns of medical practice that need to be addressed with the Medical Staff as a whole, will be discussed at the quarterly meetings of the Medical Staff.
- s. The Medical Executive Board is empowered to act on reports from medical staff committees, services, and other groups as appropriate.
- t. The Medical Executive Board will review requests by mid-level practitioner to prescribe controlled substances and will recommend to the appropriate discipline – specific Professional Standards Board reporting any limitations or restrictions on the prescriptive authority.
- u. The Medical Executive Board will provide a recommendation to the Executive Leadership Board regarding all facets of patient care services including performance improvement, goals, plans, research, mission, services affected and assists with prioritization of hospital-sponsored continuing education activities.

- v. The Medical Executive Board will review and act on reports and recommendations for performance improvement from the following Clinical Committees at least on an annual basis:
  - i) Adverse Events & Procedures Review
  - ii) Infection Prevention
  - iii) Transfusion
  - iv) Pharmacy & Therapeutics/Drug Utilization Evaluation
  - v) Cancer
  - vi) Clinical Informatics
  - vii) Utilization Review
  - viii) Staff and Patient Education
  - ix) Residency Review
  - x) CPR
  - xi) Patient Safety
  - xii) Radiation Safety
  - xiii) Research and Development
  - xiv) Ethics

3. Meetings:

- a. Regular Meetings: Regular meetings of the Medical Executive Board shall be held at least monthly. The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chairmen of the various committees of the Medical Staff shall attend regular meetings of the Medical Executive Board when necessary to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the Medical Executive Board.
- b. Emergency Meetings: Emergency meetings of the Medical Executive Board may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the Medical Executive Board, the Director as the Governing Body or Acting Chief of Staff, acting for the Chief of Staff, may call an emergency meeting of the Committee.
- c. Meeting Notice: All Medical Executive Board members shall be provided at least 7 days advance written notice of the time, date, and place of each regular meeting and reasonable notice, oral or written, of each emergency meeting.



- d. Agenda: The Chief of Staff, or in his absence, such other person as provided by these Bylaws, shall chair meetings of the Medical Executive Board. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.
- e. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the Medical Executive Board shall be a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
- f. Minutes: Written minutes shall be made and kept on all meetings of the Medical Executive Board, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff.
- g. Communication of Action: The Chair at a meeting of the Medical Executive Board at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.

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

- a. Executive Leadership Board (Quality): (ELB)
  - i) Purpose: ELB monitors and evaluates the quality of care, access to and appropriateness of care, utilization of resources necessary to provide quality of care, safety of patients, and patient satisfaction. ELB will lead the organization in planning, directing, implementing, coordinating, and improving clinical services at the VAPHS. ELB reviews and acts on reports and recommendations from medical staff committees, service lines and functional teams. ELB oversees patient care activities in the healthcare system and will ensure that deficiencies in the quality of care identified by performance measures, internal and external reviews, etc., are appropriately corrected. Recommendations for performance improvement made by ELB will be forwarded to the Director for final approval. The performance improvement model used within the VAPHS is Understand, Analyze, and Improve. This problem-solving methodology is focused on designing, measuring, accessing and improving health care outcomes and exceeding patient expectations.
  - ii) Functions: Establish and plan implementation of strategic goals and objectives. Oversee on site patient care services (acute care, ambulatory care, Nursing Home care, critical care), and off-site patient care services (community based outpatient clinics). Review and act on performance improvement reports and recommendations submitted by service lines, programs, committees, and other groups. Introduce performance improvement initiatives emphasizing collaboration and a systems approach in administration and clinical areas. Ensure compliance with regulatory and accreditation standards for appropriate accrediting boards (e.g., Joint Commission, Nuclear Regulatory Commission, College of American

Pathology, etc.). Quality of care issues investigated by the Clinical Executive Leadership Board and recommendations for corrective action will be forwarded to the Director for final approval. Provide continuous communication between leadership and staff at VAPHS.

iii) Composition:

- (1) The Chief of Staff or designee will serve as Chairperson.
- (2) Members will be appointed by the Chairperson. The following members have been designated:

Chairperson, Transfusion Committee  
Vice President, Primary Care Service Line  
Chairperson, Infection Prevention Committee  
Chairperson, Adverse Events and other Procedures Review Committee  
Vice President, Medical Specialty Care Service Line  
Vice President, Surgical Specialty Care Service Line  
Vice President, Critical Care Service Line  
Vice President, Geriatrics and Extended Care Service Line  
Vice President, Behavioral Health Service Line  
Vice President, Clinical Support Service Line  
Vice President, Patient Care Service Line  
Vice President, Community Based Care Service Line  
Chief Surgeon  
Medical Staff Member at Large  
Program Leader, Health Information Management Service  
Vice President, Business Service Line  
Vice President, Facilities Management Service Line  
Vice President, Information Management Service Line  
ACOS/Research  
Program Leader, Human Resources  
Director (or designee)  
Deputy Director / Resources  
Associate Director / Site Operations  
Associate Director/Patient Care Services  
Director, Education  
Public Relations Officer  
Quality and Patient Safety Coordinator  
Executive Assistant to Chief of Staff  
Representative, Regional Counsel  
Representatives, Local 2028 and 3344

iv) Meetings: Monthly.

- b. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing

guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Mid-Level and Allied Health Practitioners (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners and (g) for such additional purposes as may be set forth in the charges to each committee

c. Quality Management/Patient Safety Committee:

i) Charge: (a) participate in developing and implementing an integrated interdisciplinary Facility-wide program to monitor the quality and safety of patient care and to promote an effective and efficient utilization of manpower, facilities and services; (b) facilitate mechanisms for correction of problems identified; (c) review the performance monitoring activities of the *<insert names of committees overseen by Quality Management Committee>* Committees; (d) assist all Facility Services and Departments in identifying and evaluating problems in ancillary service utilization and encourage solutions which enhance quality of care; (e) fulfill the review requirements of The Joint Commission, and other external reviewing organizations; (f) report to the Chief of Staff, Medical Executive Board, and Facility Director pertinent issues concerning the quality control and performance improvement efforts.

ii) Composition: Chairpersons of the Patient Safety Subcommittees and representatives from Education, Quality and Patient Safety, and Locals 2028 and 3344.

iii) Meetings: Monthly.

d. Cardiopulmonary Resuscitation Committee:

i) Charge: To oversee the conduct of resuscitation events for acute decompensation events at the facility and to benchmark the results to national standards. The committee seeks to facilitate efforts to improve outcomes for such activities.

ii) Composition: Physicians (cardiology, critical care, anesthesia), nurses representing education, critical care, acute and long term care floors, pharmacists allied professionals including respiratory therapists, representative from purchasing and quality assurance.

iii) Meetings: monthly to bimonthly

e. Cancer Committee:

i) Charge: The cancer committee is a standing committee of the VAPHS that is responsible for directing care of patients with cancer. The committee focuses on providing state of the art care from the time of diagnosis through treatment, rehab and at the end of life. It also recognizes the importance of education and prevention.

ii) Composition: The committee is multidisciplinary and includes representatives from medical oncology, surgery, radiation therapy, nursing, pharmacy, social service, rehab, pathology and the tumor registrar.

- iii) Meetings: Quarterly.
- f. Clinical Informatics:
  - i) Charge: Provide oversight to the CPRS and HIMS communities of VAPHS. We also serve as a clearinghouse and venue for discussing all computerized clinical information products, services, and processes for VAPHS.
  - ii) Composition: Representation from all service lines, HIMS, and the COS office.
  - iii) Meetings: Monthly
- g. Commodity Standards Committee:
  - i) Charge: Reduce the number of sizes, kinds, types, and grades of items to those essential to meet VA Program requirements. Assure economical Purchasing and Distribution. Ensure all essential requirements of affected services are accommodated by obtaining concurrence of the using department(s) and Service Line VP(s) prior to standardization. Ensure that equipment and supplies for patient use proposed by using services for testing and evaluation and/or standardization comply with all patient safety and JCAHO regulations, alerts and advisories, and that all such medical equipment is checked for electrical safety.
  - ii) Composition: Representatives from financial management, acquisition, pharmacy, infection control, Medical service line, Primary Care service line, Patient Care Services, Biomedical engineering, Environmental Management, Logistics, Quality and Patient Safety
  - iii) Meetings: Virtually (Electronic) on an as needed basis.
- h. Pharmacy and Therapeutics Committee:
  - i) Charge: Recommend professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to pharmaceuticals; recommend programs designed to meet the needs of the professional staff of the Facility for complete current information on matters related to pharmaceuticals and current pharmaceutical practices. Coordinate with the Pharmacy Service and Patient Care Services to oversee management on the use of drugs at the VA Pittsburgh Healthcare System. Support and promote compliance with the VA National Formulary, as well as oversee appropriate utilization of non-formulary products. Evaluate drugs proposed for use in the VA Pittsburgh Healthcare System and forward these proposals to the Network if endorsed locally. Recommend and oversee actions pertaining to emerging medication safety issue from VA nationally, the FDA, and other drug safety organizations; review all incidents of recalled drugs to ensure that Pharmacy Service has taken appropriate action.
  - ii) Composition: Members of Medical, Nursing, Pharmacy, and Administrative Staffs
  - iii) Meetings: Monthly.

- i. Adverse Events and Procedure Review committee:
  - i) Charge: To establish a protocol for review of operative and other procedures occurring within the healthcare system in order to monitor and continuously improve performance by the medical and nursing staff. The results of these and other peer review issues will be discussed by a hospital committee of medical staff clinical leaders to evaluate the appropriateness of the reviews and the effectiveness of actions addressing issues involving procedures and other adverse events.
  - ii) Composition:
    - Chief, Pathology
    - Chief, Dental
    - Chief, Imaging Department
    - Chief of Staff
    - Critical Care Staff Member
    - Chief, Anesthesia
    - VP, Behavioral Health Service
    - VP, Clinical Support Service Line
    - Medical Director, Geriatric Service Line
    - Medical Staff Member
    - VP, Critical Care Service Line
    - VP, Medical Specialty Service Line
    - VP, Geriatric Service Line
    - VP, Primary Care Service Line
    - VP, Surgical Specialty Service Line
  - iii) Meetings: Quarterly.
- j. Compliance Committee:
  - i) Charge: Identify business processes to be monitored, business processes and health information practices to be audited, and recognize areas to be the subject of focused training and education. The CBI Officer and Compliance Committee will formulate and organize an annual formal CBI Risk Assessment which outlines the above stated information.
  - ii) Composition: HIMS Chief (Health Information Management), Chief Financial Officer, Chief-Revenue/MCCR Program, Chief-Quality Management, Representatives from the following areas: Primary Care, Surgical Service, Medical Service, Geriatrics, Mental Health, Critical Care, AFGE, Community Based Care, HAS ADPAC.
  - iii) Meetings: Monthly.
- k. Medical Staff Meeting:
  - i) Charge: Review findings, conclusions, recommendations and actions taken to improve organizational performance. Special meetings may be convened at the call of the chairperson. A quorum for purposes of medical staff meetings is defined as attendance by at least 25 members. Minutes of medical staff meetings will reflect attendance, issues discussed, conclusions,

recommendations, actions, evaluation and follow-up. All members of the active medical staff will be considered as voting members.

- ii) On an annual basis the Medical Staff will elect two Members at Large. These individuals will serve as representatives of the Medical Staff at the Executive Leadership Board, Medical Executive Board; and Commodity Standards Committee.
  - 1). A key responsibility of the Members at Large is to relay issues or concerns of the Medical Staff to the Chief of Staff and to serve on administrative or clinical groups to present the views and opinions of the Medical Staff.
  - 2). The Members at Large may be assigned to assist with peer reviews, and lead task forces, special projects, etc.
- iii) Composition: The active medical staff members will attend meetings of the medical staff as voting members unless excused for appropriate reasons e.g., illness, leave, or clinical requirements.

iv) Meetings: Quarterly

I. Infection Control Committee:

- i) Charge: Define, survey, correlate, review, evaluate, revise and institute whatever recommendations are necessary in order to prevent, contain, investigate and control nosocomial infections and other infectious diseases among patients and personnel; submit committee minutes to the Medical Executive Board quarterly; and report a summary of its activities to the MEB annually.
- ii) Composition: Infection control officer and other members of the Medical Staff including physicians and advanced practice providers; members of Nursing, Environmental Management, Food and Nutrition, Pharmacy Services, microbiology and Administrative Staffs
- iii) Meetings: Quarterly

m. Critical Care Committee:

- i) Charge: To provide safe, high-quality care through efficient utilization of resources; to implement effective administrative processes for the continuity of care, data acquisition and analysis, bed access and utilization, admission/discharge and triaging; to monitor and evaluate the quality, efficiency and appropriateness of care and Joint Commission compliance; to promote interdisciplinary planning; and to promote education and research.

ii) Composition:

Vice President CCSL  
Physician Medical Directors, CCU, MICU, SICU, SDU and ED  
Business Manager CCSL  
Nursing Program Leader CCSL  
Nurse Managers, CCU, MICU, SICU, SDU and ED

Respiratory Therapy Supervisors  
Chief of Cardiology/designee  
Chief of Anesthesiology/designee  
Chief of Medicine/designee  
Chief of Surgery/designee  
Chief of Transplant Services/designee  
CCM Non-Teaching Service Attending  
In-Patient Pharmacy Supervisor  
CCSL Education Coordinators  
Infection Control Nurse  
Social Worker, CCC  
Nursing Program Leader, Medical/Surgical Area  
Clinical Specialist/Clinical Nurse Leader, Medical/Surgical Area  
Nursing Program Leader, Surgical Specialty  
Quality and Patient Safety Representative  
AFGE Representative

iii) Meetings: Quarterly.

n. Joint Commission Readiness Teams Committee:

i) Charge: The Acute Care Readiness Team is charged with ensuring compliance with the standards and yearly scoring of the JC Periodic Performance Review (PPR) for the Provision of Care Chapter, Life Safety Chapter, Emergency Management Chapter, Environment of Care Chapter, and the Record of Care Chapter of the JC Comprehensive Accreditation Manual for Hospitals. The Long Term Care Readiness Team is charged with ensuring compliance with the standards and yearly scoring of the JC Periodic Performance Review (PPR) for the Provision of Care Chapter, Life Safety Chapter, Emergency Management Chapter, Environment of Care Chapter, and the Record of Care Chapter of the JC Comprehensive Accreditation Manual for Long Term Care. The Behavioral Health Readiness Team is charged with ensuring compliance with the standards and yearly scoring of the JC Periodic Performance Review (PPR) for the Provision of Care Chapter, Life Safety Chapter, Emergency Management Chapter, Environment of Care Chapter, and the Record of Care Chapter of the JC Comprehensive Accreditation Manual for Behavioral Health.

ii) Composition: Members of Nursing Inpatient and outpatient clinics, EMS, FMS, Safety, HIMS, Clinical Support(Pharmacy and Rehabilitation), Social Work .Assistant to the COS, 2 Physicians Liaisons, and Accreditation Specialist. Nursing Behavioral Health, CTAD, Vocational Rehab

iii) Meetings: Monthly.

o. Nutrition Committee:

i) Charge: To establish an interdisciplinary approach regarding nutrition care issues within VA Pittsburgh Healthcare System (VAPHS).

- ii) Composition: Chief or Leader, Nutrition Support Team-Chairperson, Clinical Nutrition Coordinator, service line representatives-Behavioral Health, Clinical Support (Dental, Pharmacy, Lab, Speech), Community Support, Critical Care, Medical, Surgical, Patient Care Services, Nutrition & Food Services, Primary Care and AFGE.
  - iii) Meetings: Quarterly.
- p. Operating Room Committee:
- i) Charge: Operating Room oversight including (a) Regulatory Compliance, (b) Policies and Procedures, (c) Performance, Quality and Workload Metrics, and (d) Equipment, Instruments and Supplies.
  - ii) Composition: SSSL VP / Chief of Surgery, SSSL ACN, SSSL Program Specialist, Chief of Anesthesia, NM-OR, ANM-OR, SSSL Quality RN, VASQIP RN Reviewer.
  - iii) Meetings: Twice a month.
- q. Patient Education Committee:
- i) Charge: Inform SLVPs (Service Line Vice Presidents) of Joint Commission (JC) patient education standards that must be met by clinical staff within service lines. Determine the extent to which these standards are being met and provide reports when compliance monitoring is done. Require SLVPs or their designees to take corrective actions to correct deficiencies. Communicate to the team, SLVPs needs for coordination and support in achieving Veterans' health education objectives and standards. Educate staff regarding Veterans' health education policies and practices.
  - ii) Composition: Patient Care Services nurses.
  - iii) Meetings: Every other month.
- r. Radiation Safety Committee:
- i) Charge: Ensure radiation safety for patients and personnel in compliance with applicable regulations. With the assistance of the Radiation Safety Officer oversee the use of licensed radioactive materials and radiation producing machines and review the radiation safety programs. Review research protocols involving the use of ionizing radiation and recommend changes, as necessary, before giving approval for those protocols which are not considered to be within the standard of care.
  - ii) Composition: Radiation Safety Officer, a representative from management who is neither an authorized user nor a radiation safety officer, and representatives from Patient Care Services (Nursing), Research, Radiology, Radiation Therapy, Cardiology, Nuclear Medicine and Pharmacy.
  - iii) Meetings: Quarterly.
- s. Research and Development Committee (R&D):



- i) Charge: The R&D Committee is charged with overseeing the medical center's research program. At the VAPHS, committees such as the IACUC, Institutional Bio-safety Committee (IBC), Research Scientific Evaluation Committee, and the Institutional Review Board (IRB) are technically subcommittees of the R&D Committee. The R&D Committee is responsible, through the Chief of Staff (COS), to the medical center Director for advising and assisting the medical center Director in providing oversight, planning and execution of the VAPHS research program. Additionally, the R&D Committee is responsible for assisting the medical center Director in maintaining high standards throughout the R&D Program. Those standards include ensuring the: (a) scientific and ethical quality of VA research projects, (b) the protection of human subjects in research, (c) the safety of personnel engaged in research, (d) the welfare of laboratory animals, (e) security of VA data, and (f) the security of VHA research laboratories.
- ii) Composition: The R&D Committee is comprised of Chairs of R&D Subcommittees, Directors of Centers of Excellence and representatives of key medical center service lines.
- iii) Meetings: Bi-monthly.
- t. Safety Committee:
  - i) Charge: To provide a safe, secure, healthy, accident-free environment for all patients, visitors, volunteers, and staff, by managing staff activities to reduce the risk of injuries.
  - ii) Composition:
    - Associate Director, Chairperson
    - Safety Manager
    - Industrial Hygienist
    - AFGE Local 2028 Representative
    - AFGE Local 3344 Representative
    - Associate Director, Patient Care Services/Business Manager
    - Education Representative
    - Chief, Police Service
    - Infection Control Representative
    - OWCP Management Specialist
    - Patient Care SL Representatives from UD, Heinz, HD
    - Quality and Patient Safety Service Representative
    - Associate Director for Site Management (Heinz and Highland Drive)
    - VP Facilities Management Service Line
    - Environmental Management Program Leader
  - iii) Meetings: Monthly January – October, then one meeting for Nov/December.
- u. Women's Health Performance Improvement Committee:
  - i) Charge: Coordinate an overall performance improvement program to monitor the medical care provided to women Veterans and gender related women's health services.

- ii) Composition: Members of Medical, Nursing, Radiology, Pathology, Gynecology, Pharmacy, Quality and Patient Safety, Clinical Informatics, and CBOC Women's Champions.
  - iii) Meetings: Monthly.
- v. Women Veterans' Health Committee:
- i) Charge: Recommend improvements in services and programs including consumer concerns, educational needs, and privacy issues. Improve effectiveness and efficiency of women's health care services by providing interdisciplinary cooperation. Serve as an advisory and problem-solving resource to the Chief of Staff and Medical Center Director concerning medical center policies and procedures for the provision of women's health services. .
  - ii) Composition: Members of Medical, Surgical, Emergency Medicine, Psychiatry, Nursing, Pharmacy, Community Based Care, OEF/OIF, EEO Manager, Public Affairs, Patient Advocate, Quality and Patient Safety, Facilities Management, and Women Veteran Consumers.
  - iii) Meetings: Quarterly
- w. Equipment Committee:
- Charge: The Equipment Committee reviews all equipment requests for Additional, Replacement and Hi Tech/Hi Cost equipment for the VAPHS. Each year every Service Line is requested to submit a 5 year plan identifying their equipment needs. After review, the committee recommends approval depending on the availability of funds for each appropriation (Medical, Administrative and Facilities) and the prioritization submitted by the Service. The Chairperson of the Equipment Committee, along with the Associate Director, also reviews requests for emergency purchases outside of the committee and approves for immediate funding/purchase. Property Management Staff provides administrative support and initiates requests for 5 year planning, and Hi Tech/Hi Cost submittals from Service Lines. Property Management obtains required concurrences, quotes and requests from services and creates 2237s for procurement action.
- i) Composition:  
Chairperson of Equipment Committee,  
Chief of Staff,  
Associate Director,  
Chief Biomedical Engineering,  
CFO Financial Management,  
Executive Assistant to the Director,  
Executive Assistant to the Deputy Director.  
Chief Logistics
  - ii) Meetings: Annually
- x. Ethics Committee:

- i) Charge: The Ethics Committee is a portion of the VAPHS Integrated Ethics program. This program targets three levels of individual and organizational practices—decisions and actions, systems and processes, and environment and culture—by establishing the ethics consultation service, the preventive ethics team, and an ethical leadership function, which includes the establishment of an IE council. The Ethics consultation committee responds effectively to ethical concerns throughout the medical center which is essential for both individuals and this organization>.
  - ii) Composition: physicians, nursing staff, licensed social workers, chaplains, and other individuals who have an interest in ethics.
  - iii) Meetings: Monthly.
- y. Mental Health Executive Committee:
- i) Charge: Develop and support an interdisciplinary approach to the treatment of patients seeking mental health services. Improve effectiveness and efficiency of mental health services by promoting interdisciplinary cooperation. Assess the impact of the physical, psychological, social, and structural environment of the facility on patients and families, and seek resolution of identified problem areas. Identify mental health needs and objectives for various categories of patients within the VA Pittsburgh Healthcare System. Initiate collaborative efforts in program planning among interested service lines. Serve as problem solving resource to the VA Pittsburgh Healthcare System divisions for short and long-range issues. Develop policies and procedures to monitor the provisions of mental health services at the VA Pittsburgh Healthcare System.  
  
Develop a system to ensure continuity of mental health services provided at the VA Pittsburgh Healthcare System and other facilities. Serve as an advisory and problem solving resource to the Chief of Staff and Medical Center Director concerning medical center policies and procedures for the provision of mental health services.  
  
Coordinate an overall quality improvement program to monitor mental health services.  
  
Review Behavioral Health Programs as well as Quality and Patient Safety monitors at least quarterly. The reviews will include usage of restraint and seclusion; Code Blue; Patient on Patient and Patient on Staff Assaults; Patient Incidents; Disruptive Behavior Subcommittee report; and Military Sexual Trauma reports, as well as review the minutes from the Mental Health Council Meeting. Annually the council will review and revise, as needed, the existing policy on the use of locked wards in the VA Pittsburgh Healthcare System to assure that patients are in the least restrictive environment consistent with responsible practice. Review and revise, as needed, existing policies on
    - a. patient rights, privileges and responsibilities
    - b. restraints and seclusion

- c. management of suicidal behavior
- d. psychiatric emergency intervention team, code blue.

Considers the mental health of all veterans served by VA Pittsburgh Healthcare System and of staff, and attends to the impact on the emotional well-being of veterans and staff of Medical Center policies, procedures, and programs.

ii) Composition:

Chairperson: Vice President, Behavioral Health Service Line  
Designated representative of: Community Based Care Service Line  
Chaplain Representative, Highland Drive  
Clinical Nurse Specialist, Behavioral Health Service Line, University Drive  
Clinical Nurse Specialist, Patient Care Services, H.J. Heinz Division  
Program Leader, Patient Care Services, Highland Drive  
Primary Care Service Line, University Drive  
Representative from Geriatrics and Extended Care Service Line  
Representative from Quality and Patient Safety  
Representative for Education, Highland Drive  
Safety Representative, Highland Drive  
Business Manager, Behavioral Health Service Line, Highland Drive  
Administrative Officer, Behavioral Health Service Line  
Mental Health Consumer Council Representative  
Local Recovery Coordinator  
Recording Secretary, Behavioral Health Service Line, Highland Drive

iii) Meetings: Quarterly.

z. Pain Management Committee:

i) Charge: Recommend professional policies regarding evaluation and implementation of safe and best practice and other matters pertinent to pain management; recommend educational programs designed to meet the needs of the professional staff of the Facility for complete current information on matters related to pain management

ii) Composition: Members of Medical, Nursing, Pharmacy, behavioral health, physical therapy and Administrative Staff.

iii) Meetings: Quarterly

aa. Transfusion Committee:

i) Charge: The role of Transfusion Committee is to oversee the activities of the Transfusion Service as a whole, and educate its staff regarding safe and effective transfusion practices. Activities of the Committee will include but not be limited to:

- (1) Follow national guidelines and develop local guidelines for clinical use of blood.
- (2) Develop policies and procedures for blood transfusion in the facility

- (3) Monitor and clinically review (concurrently or retrospectively) all blood transfusions to ensure appropriate and correct usage of blood thereby reducing unnecessary transfusion and avoiding wastage.
  - (4) Reviewing all QA data generated by the transfusion service
  - (5) Recommend corrective actions in transfusion practice
  - (6) Make arrangements for training of house and clinical staff based on policies and procedures.
  - (7) Establish criteria for review of utilization of blood and blood products in individual cases
  - (8) Make periodic reports to the Medical Board
  - (9) Develop audit criteria for transfusion practice and peer review
  - (10) Assess blood and blood component use for ways to improve patient care
  - (11) Review and analyze statistical reports of the transfusion service
  - (12) Assist the blood suppliers in blood procurement efforts
  - (13) Assess adequacy and safety of the blood supply.
  - (14) Promote continuing education in transfusion practices for the hospital staff.
- ii) Composition: Representatives from Pathology and Lab Services, Blood Bank, Surgical Specialties, Medical Specialties, Anesthesia, Critical Care, Nursing and Education, Quality and Patient Safety and Emergency Medicine.
- iii) Meetings: Quarterly
- bb. Visual Impairment Committee (VIST):
- i) Charge: To coordinate available resources to assist Veterans who are blind or visually impaired in maintaining satisfactory adjustments through the changing circumstances of life and advancing years. The VIS Team will ensure that all eligible veterans are informed of VIST services.
  - ii) Composition: The VIST team is interdisciplinary and will consist of representatives from the following services:
    - (1) Ophthalmology, LV Optometrist, ADPAC, Audiology, BROS, Clinical Support Leadership, Library service, Nursing, Nutrition, Podiatry, Primary Care, Prosthetics, Psychology, Quality Improvement, Social Work, State/Community Blindness Agency, Veterans Benefit Administration, Veteran Representatives, Blinded Veterans Association (BVA), VIST Coordinator
    - (2) The VIST members will be identified as the facilitator in their service to help the visually impaired Veteran access their service and be the point of contact for problem identification. They will bring these issues to the attention of the team to help develop a solution. The VIST members will also be responsible for educating and sensitizing their co-workers about

the needs of the legally blind Veteran. It is hopeful that these efforts will assist the visually impaired Veteran in obtaining the services he/she needs to function as independently as possible.

iii) Meetings: Quarterly.

cc. Heinz Core Management Committee

i) Charge: The committee oversees continuous quality / performance improvement of the departments and services within the Community Living Center. The committee receives / reviews reports on quality /performance improvement. The committee also serves as a communication mechanism to relay information throughout the departments and services within the Community Living Center.

ii) Composition: The committee is comprised of representatives from each service line / department within the Community Living Center. Nursing representation includes subject matter experts in the Minimum Data Set (MDS), infection control (MRSA, etc.), falls, and Joint Commission preparation. The committee also includes representation from the residents.

iii) Meetings: Monthly.

dd. Resident Review Committee:

i) Charge: The Residency Review Committee provides a mechanism by which the VAPHS in collaboration with the Medical Executive Board and University of Pittsburgh Medical Center Medical Education (UPMCME) oversee Graduate Medical Education (GME) at the VA Pittsburgh Healthcare System. The Committee evaluates, reviews and makes recommendations with respect to processes for evaluating the professional performance, educational achievement, supervision, discipline, and termination of residents as it relates to GME. Recommendations and information from the Committee related to the safety and quality of patient care, treatment and services, and educational needs of participants in the professional graduate education program will be communicated to the Medical Executive Board and Facility Director to the UPMC Office of GME for appropriate action. The Resident Oversight Committee will also:

- (1) Monitor reports of findings from medical record reviews for compliance with VA standards of resident supervision by staff practitioners for inpatient admissions and outpatient visits involving residents.
- (2) Monitor the supervision of diagnostic and therapeutic procedures and consultations involving residents to ensure consistency with graduated levels of resident supervision.
- (3) Monitor all incidents and risk events with complications to ensure that the appropriate level of supervision occurred.
- (4) Complaints or concerns expressed by staff, patients, families etc, about the safety and quality of care, treatment and services provided by or through House staff will be appropriately addressed by the Residency

Oversight Committee and referred to the Medical Executive Board when corrective action is indicated (i.e. educational need).

- (5) Review citations of all accreditation and certifying bodies concerns and provide follow up with corrective action as needed to ensure compliance.
- (6) Review resident evaluation comments related to the VA training experience and implement recommended changes (e.g. orientation program).
- (7) The Annual Report on Residency Training Program (RCN 10-0906) will be submitted to the Medical Executive Board through the Resident Oversight Committee for review. The report will encompass the status of the training programs in the medical center, any action taken by accreditation or certifying bodies, any changes in the status of the affiliation, and any resident supervision results identified through the monitoring process
- (8) A Residency Oversight Committee will be established each academic year.

ii) Composition:

- (1) A chairperson will be appointed by the Chief of Staff. The Chairperson is a member of the VAPHS Medical Staff with an interest and demonstrated expertise in training residents.
- (2) The Committee will be co-chaired by the Associate Chief of Staff for Education (ACOSE). Membership will include the following or their designees: Chief of Staff, Chief of Medicine, Chief of Surgery, Associate Director of Patient Care Services and chiefs of the facility's clinical services in which residency programs exist, inclusive of Dental. The UPMC GME Office will be invited to send one member.
- (3) Membership will also include at least one senior resident (PG2 or higher) of the facility. Only residents who spend three or more months at the VA facility shall be eligible for appointment.
- (4) At the discretion of the Facility Director, a physician or dentist who serves in a consulting or attending status may be appointed as a non-voting ex-officio member.

iii) Meetings: Monthly

2. Information Flow to MEB: All Medical Staff Committees, including but not limited to those listed above, will submit minutes of all meetings to the MEB in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the MEB.
3. All Committees and teams are charged with assuring that the healthcare system is in compliance with VA regulations, Joint Commission standards, American College of Surgeons Cancer Program standards, and other applicable accreditation standards. Each committee and team is responsible for contributing to the healthcare system-wide approach to quality assessment, improvement and

management. The purpose, function, membership and organization of specific committees are delineated in specifically entitled healthcare system memoranda.

4. Medical staff members, or their designated alternates, will attend at least 50% of meetings of committees of which they are members unless specifically excused by the committee chairperson for appropriate reasons, e.g., illness, leave, clinical requirements, etc. Committee minutes will specify attendance and members will attend the meeting on time and until the business has been concluded.

#### **Section 5.04 Committee Records and Minutes**

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

#### **Section 5.05 Establishment of Committees**

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

### **ARTICLE VI. MEDICAL STAFF MEETINGS**

1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least annually. A record of attendance shall be kept.
2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the MEB. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Director in writing and stating the reason(s) for the request.
3. Quorum: For purposes of Medical Staff business, no less than twenty-five (25) percent of the total membership of the medical staff membership entitled to vote constitutes a quorum.



## **ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING \***

### **Section 7.01 General Provisions**

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

4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:
  - a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.
  - b. Federal law authorizing VA to contract for health care services.
5. Initial Focused Professional Practice Evaluation:
  - a. The initial focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This occurs with a new Practitioner or an existing Practitioner who request a new privilege. The performance monitoring process is defined by each Service and must include;
    - i) Criteria for conducting performance monitoring
    - ii) Method for establishing a monitoring plan specific to the requested privilege
    - iii) Method for determining the duration of the performance monitoring
    - iv) Circumstances under which monitoring by an external source is required.
  - b. An initial Medical Staff appointment does not equate to HR employment. FPPE does not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below;
    - i) Initial and certain other appointments made under 38 U.S.C. 7401(l), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations.
    - ii) If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply the same processes to the evaluation of individuals employed under provision of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.
6. Ongoing Professional Practice Evaluation:
  - a. The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. Ongoing professional practice evaluation (OPPE) is a process that continuously evaluates a practitioner's professional performance to identify practice issues that may impact quality of care and patient safety. Ongoing professional practice evaluation is an evidence-based privilege renewal process and is part of a decision-making process that will be used on an annual basis to continue a provider's existing privilege(s) or scope(s) of practice, or to limit or revoke existing privilege(s) or scope(s) of practice prior to or at the time of renewal. Each Service Line Vice President should consider what hospital, regional, state, national, and

- specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate. Electronic databases may be accessed to assess professional practice related to review of:
- i) Operative and other clinical procedures performed and their outcomes;
  - ii) Patterns of blood and pharmaceutical usage;
  - iii) Requests for tests and procedures;
  - iv) Length of stay patterns;
  - v) Morbidity and mortality data;
  - vi) Use of consultants;
  - vii) Performance Measures;
  - viii) Resident supervision;
  - ix) Medical record management, etc.
- b. Other information that may added by the Service Line to an ongoing professional practice evaluation may include:
- i) Periodic chart review
  - ii) Direct observation;
  - iii) Monitoring of diagnostic and treatment techniques;
  - iv) Discussion with other individuals involved in the care of each patient including consultants, assistants in surgery, nursing, and administrative personnel;
  - v) Compliance with hospital policies;
  - vi) Compliance with mandatory training
- c. Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. If there is uncertainty or concerns have been reported regarding the practitioner's professional performance, the Medical Executive Board may request a further investigation. Information resulting from the professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s). Privileged practitioners have access to the fair hearing and appeal process of the intervention results in corrective action.
- i.) Service Line Vice Presidents must be able to demonstrate that relevant practitioner data is reviewed on regular bases (i.e. more than once a year). Consideration may be based on a period of time or a specified number of procedures, and may consider high risk or high volume for an adjustment to the frequency.

- ii.) With very few exceptions, VHA data standing alone is not protected by 38 U.S.C. 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. Data that is not previously identified as protected by 38 U.S.C. 5705 and is collected as provider-specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program, and compared to pre-defined facility triggers or de-identified quality management data.
- iii.) In those instances where a practitioner does not meet established criteria, the Service Line Vice President has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a Service Line Vice President recommending the renewal of privileges, but the Service Line Vice President must clearly document the basis for the recommendation of renewal of privileges.
- iv.) The Executive Committee of the Medical Staff must consider all information available, including the Service Line Vice President's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.
- v.) The Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

### **Section 7.02 Application Procedures \***

1. **Completed Application:** Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines. **NOTE:** See VHA 1100.19 for full process. The applicant is bound to be forthcoming, honest and truthful (1100.19 page 9). To be complete, applications for appointment must be submitted by the applicant on forms approved by the VHA, entered into the internet-based VHA VetPro credentialing database, and include authorization for release of information pertinent to the applicant and information listed below. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the Practitioner says the information provided is factually incorrect.
  - a. Items specified in Article III, Section 2, Qualifications for Medical Staff Membership, including:
    - i) **Active, Current, Full, and Unrestricted License:** **Note:** In instances where Practitioners have multiple licenses inquiry must be made for all licenses and

*the process as noted in VHA Handbook 1100.19 must be followed for each license (38USC 7402). Limitations defined by state licensing authorities must also be considered when considering whether licensure requirements are met.*

- ii) Education.
  - iii) Relevant training and/or experience.
  - iv) Current professional competence and conduct.
  - v) Physical and Mental health status to perform the requested privileges.
  - vi) English language proficiency.
  - vii) Professional liability insurance (contractors only).
  - viii) BLS approved program using criteria by the American Heart Association. Clinically active staff nominally includes all physicians, mid-level providers and nurses.
  - ix) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and will acknowledge that they have received a copy of "The Sedation and Analgesia by Non-Anesthesia Providers" policy and agree to the guidelines outlined in the policy. They must also be certified in Advance Cardiac Life Support (ACLS).
- b. U.S. Citizenship: Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, Practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment with proof of current visa status and Immigration and Naturalization Service documentation regarding employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.
- c. References: The names and addresses of a minimum of four individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer or for individuals completing a residency; one reference must come from the residency training program director in the case of individuals completing a residency. The Facility Director may require additional information.
- d. Previous Employment: A list of all health care institutions or other organizations where the Practitioner is/has been appointed, utilized or employed (held a professional appointment) within the past 10 years, including:
- i) Name of health care institution or practice.
  - ii) Term of appointment or employment and reason for departure.

- iii) Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary surrender.
  - e. DEA/CDS Registration: A description of:
    - i) Status, either current or inactive.
    - ii) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, the Practitioner's Drug Enforcement Administration (DEA) registration.
  - f. Sanctions or Limitations: Any sanction or penalty by any licensing authority, including current pending challenges, whether a license or registration ever held to practice a health occupation by the Practitioner has been suspended, revoked, voluntarily surrendered, or not renewed.
  - g. Liability Claims History: Status (Open, Pending, Closed, Dismissed, etc.) of any claims made against the Practitioner in the practice of any health occupation including final judgments or settlements, if available.
  - h. Loss of Privileges: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.
  - i. Release of Information: Authorization for release of information, including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.
  - j. Pending Challenges: Pending challenges against the Practitioner by any hospital, licensing agency, professional group, or society.
2. Primary Source Verification: In accordance with VHA Handbook 1100.19 Credentialing and Privileging and VA Handbook 5005, Part II, Chapter 3 the facility will obtain primary source verification of:
- a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article III, Section 2a above.
  - b. Verification of current or most recent clinical privileges held, if available.
  - c. Verification of status of all licenses current and previously held by the applicant. Verification of current licensure through the primary source Internet site or by telephone is acceptable and must be documented.
  - d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed, or the United States Medical Licensing Examination (USMLE), which is a common evaluation system for foreign medical graduates, who aspire to enter U.S. medical education and health care systems.
  - e. Evidence and verification of board certification or eligibility, if applicable.

- f. Verification of education credentials used to qualify for appointment including all postgraduate training.
  - g. Evidence of registration with the National Practitioner Data Bank (NPDB) Proactive Disclosure Service and the Healthcare Integrity and Protection Data Bank, for all members of the Medical Staff and those Practitioners with clinical privileges.
  - h. For all physicians screening will be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner.
  - i. Confirmation of health status on file as documented by a physician approved by the Organized Medical Staff. The request for an evaluation will be determined by the Medical Executive Board. A pre-employment physical, including random drug testing, is required of all full-time, part-time and intermittent employees. Physical examination will be conducted by the Employee Health Service. Final employment is contingent upon the physical examination reflecting no results that would impair the physician's ability to perform the assigned duties competently. Instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an internal or external sources may be required.
  - j. Evidence and verification of the status of any alleged or confirmed malpractice. **NOTE:** *It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the Practitioner, requesting all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the Practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint. Questions concerning applicants, who may qualify for appointment under the Rehabilitation Act of 1974, need to be referred to Regional Counsel.*
  - k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made.
3. The applicant's attestation to the accuracy and completeness of the information submitted.
  4. **Burden of Proof:** The applicant has the burden of obtaining and producing all needed information for a proper evaluation of the applicant's professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of the request to the applicant may serve as a basis for denial of employment consideration.
  5. **VetPro Required:** All healthcare providers must submit credentialing information into VetPro as required by VHA policy.

6. Manual Submission for Researchers: All research providers not having a medical licensure, ECFMG, or fifth pathway require manual submissions. All providers requiring manual submission must follow the process as described in the VHA Handbook 1100.19 Credentialing and Privileging.

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

1. Service Line President Recommendation: The Service Line Vice President or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met. By applying for appointment to the medical staff/specified clinical staff, the applicant:
  - a. Signifies a willingness to bear the necessary expense to appear for interviews in regard to the application.
  - b. Authorizes Medical Center representatives to consult with associates who may have information bearing on competence and qualifications.
  - c. Consents to the inspection by VA Pittsburgh Healthcare System representatives of all records and documents that may be material for an evaluation of ethical and professional qualifications for staff membership and ability to carry out the requested clinical privileges.
  - d. Releases from all liability any VA Pittsburgh Healthcare System representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and credentials.
  - e. Releases from all liability, organizations that in good faith and without malice provide information, including otherwise privileged or confidential information, to Medical Center representatives concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges.
  - f. Authorizes and consents to VA Pittsburgh Healthcare System representatives providing other hospitals, professional associations, and other organizations concerned with physician performance and the quality of patient care with any information relevant to such concerns the Medical Center may have about the applicant, and releases medical center representatives from liability for so doing, provided that such information is furnished in good faith and without malice.
2. The Deans Committee: The Deans Committee may nominate for consideration by the Director, full and part-time physicians and dentists, including Service Line Vice President and consultant and attending staff. The Medical Executive Board recommends medical staff appointment to the Director based on evaluation of credentials of each applicant and a determination that medical staff criteria for clinical privileges are met.
3. CMO Review: In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be submitted to the VISN Chief Medical Officer (CMO) for review and recommendation as to whether to continue



the appointment and privileging process prior to presentation to the Medical Executive Board if the response from the NPDB-HIPDB query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of \$550,000 or more, or (c) two medical malpractice payments totaling \$1,000,000 or more. The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Line Vice President's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

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

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

1. Evaluation of Competence: Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the Practitioner applying for clinical privileges has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.
2. Good Faith Effort to Verify Credentials: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The entry will describe the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. It will also indicate when a secondary source, e.g. copy of diploma, confirmation from someone in practice or training at the same time, is being used in lieu of primary-source verification. The applicant should assist

in providing required information for this documentation. **Note:** *Verification of licensure is excluded from good faith effort in lieu of verification.*

- A. Before granting clinical privileges, the Chief of Staff will assure that the following information is on file and verified with primary sources, as applicable to ensure that patients will receive quality care, services, and treatment:
  - i) Current and former licenses in all states.
  - ii) Current and former DEA license and/or registration.
  - iii) National Practitioner Data Bank query.
  - iv) Physical and mental health status information from applicant.
  - v) Physical and mental health status confirmation and professional competence information from peers or service line leaders.
  - vi) Continuing education to meet any requirements for privileges requested.
  - vii) Board certification(s) and/or other advance clinical education.
  - viii) Relevant practitioner-specific data are compared to aggregate if such data are available.
3. Maintenance of Files: A complete and current Credentialing and Privileging (C&P) file including the electronic VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the C&P file is the responsibility of the Chief of Staff. Any time a file is found to lack required documentation, without an entry as noted above in paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain the documentation.
4. Credentialing Collegiality: Credentialing information may be shared with another VA facility when the practitioner has requested clinical privileges at another VA facility. The credentials information may be shared via a credentials transfer brief or via VetPro.
5. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a “for-cause” event requiring a focused review.
  - A. A FPPE, implemented at time of initial appointment, will be based on the Practitioner’s previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, chart reviews, etc. and should be discussed with the Practitioner by the Service Line Vice President.
  - B. A FPPE at the time of request for additional privileges will be for a period of time a number of procedures, and/or chart review to be set by the Vice President of the Service Line.
  - C. A FPPE initiated by a “for-cause” event will be set by the Service Line Vice President. FPPE for cause, where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges i.e., summary suspension
  - D. The FPPE monitoring process will clearly define and include the following:

- i) Criteria for conducting the FPPE. This is a time-limited process (90 days for new hires), that will be used when a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization's setting. A focused professional practice evaluation will also be used when a provider requests new clinical privileges or scopes of practice or if questions arise regarding a practitioner's practice that affect the safety or quality of patient care. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform requested privileges or scope of practice. The time period for review may be extended if performance issues have not been fully resolved.
- ii) Method for monitoring for specifics of requested privilege.
- iii) information for a focused professional practice evaluation may include:
  - (a) Chart Review
  - (b) Monitoring clinical practice patterns
  - (c) Simulation
  - (d) Proctoring
  - (e) External peer review.
  - (f) Discussion with other individuals involved in the care of each patient (e.g. consulting physicians, surgical assistants, nursing or administrative personnel).
- iv) Statement of the "triggers" for which a "for-cause" FPPE. Triggers are single incidents or evidence of a clinical practice pattern that generate a need for performance monitoring. Triggers for a "focused" professional practice evaluation will be initiated when:
  - (1) A new employee with clinical privileges or a scope of practice has credentials to suggest competence, but additional information or a period of evaluation is needed to confirm the new employee's competence in the organization's setting.
  - (2) An employee has requested a new clinical privilege or scope of practice.
  - (3) A practitioner requires supervision for a new procedure or modality to be performed at the VAPHS.
  - (4) The Service Line has questioned a practitioner's competency in relation to a sentinel event, a provider-specific tort settlement, a substantiated practitioner-specific complaint, a significant safety violation, or repeated or egregious unprofessional behavior.

- (5) Concerns have been raised by the Adverse Events and Procedure Review Committee or Medical Executive Board regarding the performance of one or more practitioners.
- v) Measures necessary to resolve performance issues which will be consistently implemented.
- E. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the Service's policies and procedures.
- F. If at any time the Service Line Vice President or designee cannot determine the competence of the Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Line Vice President:
  - i) Extension of FPPE review period
  - ii) Modification of FPPE criteria
  - iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner)
  - iv) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported )
- g. The Service Line Vice-President will review the documentation regarding the provider's performance and will provide a recommendation to the Medical Executive Board.
  - i) The Medical Executive Board will provide a final determination of whether the practitioner is competent to be granted full privileges.
  - ii) If the focused professional practice evaluation identified that the provider is unable to perform the procedure(s) independently, the provider may elect to withdraw the request for full privileges without incurring an adverse action.
  - iii) If the provider was unable to complete the number of required cases during the initial provisional or supervised period, an extension may be requested by the provider. An extension will be considered only if the provider concurs with provisional or supervised privileges during the extension period. The Service Line must concur with the extension and submit the request to the Medical Executive Board for approval.
  - iv) At the request of the practitioner, and with concurrence of the Service Line Vice-President, the Medical Executive Board may increase the number of cases to be performed during the period of provisional or supervised privileges to provide additional educational opportunities for the practitioner.
  - v) If the provider disagrees with the findings of the focused professional practice evaluation, an appeal may be filed for adjudication by the Chief of Staff or Designee.
- h. If concern for patient safety is raised at any time during the period of time that the provider has provisional or supervised privileges or following the appeal process,

the provider's full privileges will be denied and the action will be reported as a reduction or revocation of privileges to the National Practitioner Data Bank.

- i. Noncompliance with any element of the provisional or supervised privileging process will be cause for review by the Medical Executive Board and may result in suspension of provisional or supervised privileges. Suspension of provisional or supervised privileges is considered an adverse action and is reportable to the National Practitioner Data Bank.

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

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

## **ARTICLE VIII CLINICAL PRIVILEGES \***

### **Section 8.01 General Provisions**

1. Clinical privileges are granted for a period of no more than 2 years and are renewed at least every two years based on a birthday cycle except for contract providers. Privileges of contracted providers will automatically expire after one year if the contract will not be renewed. All privileges at this healthcare system pertain to the treatment of the adult and geriatric population only. Admitting privileges are granted to physicians, oral surgeons and dentists.
2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Line Vice President at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.
  - a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.
  - b. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.
3. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Medical Executive Board. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7).

4. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Vice President of the Service Line.
5. Associated Health and Mid-Level Practitioners who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.
6. Requirements and processes for requesting and granting privileges are the same for all Practitioners who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
7. The process for granting clinical privileges will be delineated by Medical Executive Board (e.g. level of training and experience, patient risk categories, etc.) and will be documented in the healthcare system's policy on credentialing and privileging. When privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for granting of privileges.
8. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all Vice Presidents must recommend the practice.
9. Clinical privileges granted to an applicant will be provider specific and setting-specific. Setting-specific privileges are granted not only based upon the provider's qualifications, but also upon consideration of the procedures and types of care and treatment and services that can be performed or provided within the setting. The availability of equipment, qualified support personnel, and other resources may impact the granting of privileges for a particular setting. Practitioners who do not have the specified privileges for a specific setting are not to practice in that setting. If a procedure is performed by more than one service within the healthcare system, the requirements or standards for granting clinical privileges will be the same among each of the services within the healthcare system. One standard of care will be guaranteed regardless of practitioner, service, or location within the healthcare system.
10. Granting, renewal, or revision of clinical privileges is also based on the individual's demonstrated current competence. For renewal or revision of privileges, this may be determined, in part, by the results of other assessment and improvement activities. Specific instances of treatment outcomes and their results of other assessment and improvement activities may also be included. An evaluation of the applicant's clinical judgment and technical skills in performing procedures and inpatient treatment and management is also included in an evaluation of current competence. Biennial reappraisal of each Medical Staff member and any other practitioner who holds clinical privileges is required. The reappraisal process will

include the practitioner's statements regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; voluntary or involuntary limitation, reduction or loss of privileges at another hospital; voluntary or involuntary termination of medical staff membership; any evidence of an unusual pattern or an extensive number of professional liability actions resulting in a fraud judgment against the applicant, mental and physical status (as it relates to the ability to perform the requested clinical privileges); and any other reasonable indicators of continuing qualifications. Additional information regarding licensure/certification status; NPDB, query; peer recommendations; continuing education accomplishments; and copies of clinical privileges held at other institutions will be secured for review. Evaluation of professional performance, judgment, clinical and/or technical competence and skills is to be based on peer recommendations and provider specific data as compared to aggregate data when available. Ongoing reviews conducted by Service Line Vice-Presidents will include, when applicable, information from surgical case review; infection control reviews; drug usage evaluations; medical record review; blood usage review; pharmacy and therapeutic review; morbidity and mortality data when available, monitoring and evaluation of quality, utilization, risk management, and appropriateness of care. The reappraisal process should 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.

11. Exercise of clinical privileges within any Service is subject to the rules of that Service and to the authority of that Vice President of the Service Line.
12. When certain clinical privileges are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.
13. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.
14. Teleconsultation: All Practitioners providing teleconsultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.
15. The process of appraisal and granting privileges for the Chief of Staff will be uniformly applied. The Chief of Staff's requests for privileges will be reviewed and a recommendation made by the relevant Service Line responsible for the specialty area in which the privileges are requested. When the Chief of Staff is considered for privileging, the Chief of Staff will be absent from the deliberations of the MEB and another member of the Board will serve as Chairperson.

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

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct,

and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.

2. Requests in Writing: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.
3. Credentialing Application: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
  - a. Complete appointment information as outlined in Section 2 of Article VI.
  - b. Application for clinical privileges as outlined in this Article.
  - c. Evidence of professional training and experience in support of privileges requested.
  - d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Medical Executive Board.
  - e. A statement of the current status of all licenses and certifications held. Failure to maintain current, active licensure, registration and/or certification will result in a non-patient care assignment and ultimately separation from the VAPHS if the license has not been renewed before the expiration date or end of the grace period as designated by the state of licensure.
  - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
  - g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.
  - h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
  - i. Response time (for on-call responsibilities) as defined by the Service Line.
  - j. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association.
4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.



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

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

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:
  - a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Line Vice President prior to formal submission of privilege requests.
  - b. Supporting documentation of professional training and/or experience not previously submitted.
  - c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Medical Executive Board.
  - d. Documentation of continuing medical education related to area and scope of clinical privileges, (consistent with minimum state licensure requirements) not previously submitted.
  - e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.
  - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
  - g. Names and addresses of two peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
  - h. Names of other hospitals or facility at which privileges are held and requests for copies of current privileges held.

2. Verification: Before granting subsequent clinical privileges, the Credentialing and Privileging Office will ensure that the following information is on file and verified with primary sources, as applicable:
  - a. Current and previously held licenses in all states.
  - b. Current and previously held DEA/State CDS registration.
  - c. NPDB-HIPDB PDS Registration.
  - d. FSMB query
  - e. Physical and mental health status information from applicant.
  - f. Physical and mental health status confirmation.
  - g. Professional competence information from peers and Service Line Vice President, based on results of ongoing professional practice monitoring and FPPE.
  - h. Continuous education to meet any local requirements for privileges requested.
  - i. Board certifications, if applicable.
  - j. Quality of care information.

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

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

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

1. Two peer recommendations will be obtained from providers in the same specialty that can provide authoritative information regarding training/experience, professional competence and conduct, any effect on the privileges being requested, and health status. At least one of the two peer recommendations should be obtained from a provider in the same sub-specialty (when feasible), who had recent contact (within the past two years) and knowledge of the person who is being recommended.

2. The Service Line Vice President where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.
  - a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:
    - i) Medical/Clinical knowledge (education competency). Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, social services, and the application of their knowledge to patient care with the education of others.
    - ii) Interpersonal and Communication skills (documentation; patient satisfaction). Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patient's families, and other members of health care teams.
    - iii) Professionalism (personal qualities). Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession and society.
    - iv) Patient Care (clinical competency). Technical and clinical skills that practitioners are expected to provide that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of diseases and care at the end of life.
    - v) Practice-based Learning & Improvement (research and development). Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.
    - vi) System-based Practice (access to care). Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize health care.
  - b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE.

- c. The decision to grant or deny a privilege(s) and/or review an existing privilege(s) is a consistently objective, evidence-based process. Decisions regarding appointment, reappointment, and initial, renewed or revised clinical privileges are rendered based on the merits of the applicant's credentials. Gender, race, creed, or national origin is not used in the decision making process. Decisions on membership and granting of privileges will consider the following criteria that are directly related to the quality of care, treatment, and services:
      - i) Current licensure, and/or certification, as appropriate, verified with the primary source.
      - ii) The applicant's specific relevant training, verified with the primary source.
      - iii) Evidence of physical ability to perform the requested privileges
      - iv) Data from professional practice review by an organization(s) that currently privilege the applicant (if available).
      - v) Peer and/or faculty recommendation.
      - vi) When renewing privileges, review of the practitioner's performance within the organization.
      - vii) Assurance by the involved Service Line(s) that the appropriate resources are available to support the required privilege(s): space, equipment, staffing, and financial resources.
3. A practitioner may request a change in privileges by forwarding a written request and supporting documentation through the appropriate Service Line Vice President to the Chairperson, Medical Executive Board.
4. The Service Line Vice President is responsible for assessing all practitioner-specific information and recommending approval of clinical privileges. Essential information, such as space, equipment, and staffing to support the requested privilege is gathered in the process of granting, renewing, or revising clinical privileges. If the Service Line Vice President is the applicant, then the Chief of Staff will be responsible for assessing all information and recommending approval of clinical privileges.
5. Requests to perform new procedures at the VAPHS must be approved by the Medical Executive Board. The criteria for granting a new privilege to a practitioner with a record of competent professional performance of the organization should include information from the practitioner's professional practice evaluation data that are collected and assessed on an ongoing basis. For the applicant who does not have a current professional performance record at the privileging organization, current data should be collected during a time limited period of privilege-specific professional performance monitoring conducted at the organization. Prior to granting of a privilege, the resources necessary to support the requested privilege must be determined to be currently available, or available within a specified time frame.

6. Medical Executive Board (MEB), the committee responsible for the Medical Executive Function, recommends granting clinical privileges to the Facility Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. A subcommittee of MEB can make the initial review and recommendation but this information must be reviewed and approved by the MEB.
  - A. Administrative disapproval of clinical privileges may be based on one or more of the following reasons:
    - a. The privilege is not a requirement for the provider's position;
    - b. The provider lacks sufficient training certification;
    - c. The provider lacks a sufficient case number to maintain competency;
    - d. The procedure is not performed at the VAPHS;
    - e. Supportive resources are not available at the VAPHS for this privilege.
  - B. Requests to the MEB to increase privileges will be accompanied by the appropriate documentation which supports the practitioner's assertion of competence, i.e. advanced education or clinical practice program, clinical practice information from other institution(s), reference, etc. Licensure, NPDB, and any additional education credentials will be verified before any new clinical privileges are granted.
  - C. Changes in the healthcare system's mission, emergence of new technologies, failure to perform a sufficient number of operations/procedures to maintain proficiency, or non-use of privileges for a high risk procedure or treatment over a period of years, may affect the Service Line Vice President's recommendation for renewal of privileges. These changes will not be construed as a reduction, restriction, loss, or revocation of clinical privileges and are not reportable to the National Practitioner Data Bank.
  - D. An applicant may require privileges outside his/her area of specialty. The applicant needs to provide a list of procedures for which (s)he feels qualified to perform and evidence of training for the designated procedures. The applicant's Service Line Vice President is to consult with the program leader responsible for the area which the applicant is requesting privileges for, and obtain a recommendation regarding the applicant's qualifications. The applicant's Service Line Vice President may make a recommendation that the applicant be subject to peer review by the program leader most familiar with the privileges being requested. The recommendations regarding the requested privileges are then forwarded to the Medical Executive Board for review.
7. Clinical privileges are acted upon by the Director within 30 calendar days of receipt of the MEB recommendation to appoint. The Director's action must be verified with an original signature.
8. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A Copy of approved privileges is given to the

Practitioner and is readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.

9. The approval of the scope of practice and prescriptive authority for Mid-Level and Associate Health Practitioners lays with the professional standards board for each discipline.
10. Failure to file a completed application for reappointment in a timely manner will result in expiration of clinical privileges. The provider will be notified by certified mail return receipt requested.
11. Following the Director's approval, limitation, or denial of a provider's clinical privileges, a copy of the clinical privileges is promptly forwarded to the provider and to the Service Line by the Credentialing Office. Prior to the official notification, the Service Line Vice President may discuss the recommendations made by the Medical Executive Board with the provider, so that the provider is aware of any pending changes in clinical privileges. Providers are informed regarding the outcomes of their requests for clinical privileges and are provided a copy of their approved clinical privileges. Approved clinical privilege documents are placed in the individual practitioner credentialing and privileging file. An electronic file of each practitioner's clinical privileges is available to designated healthcare system staff. This mechanism is intended to ensure that individuals with clinical privileges only provide services within the scope of privileges granted. The electronic file of clinical privileges is updated as changes in clinical privileges for each practitioner are made.

#### **Section 8.06 Exceptions\***

1. Temporary Privileges for Urgent Patient Care Needs: Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of an initial appointment for a limited period of time (not to exceed 60 calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff.
  - A. Temporary privileges are based on verification of the following:
    - i) One, active, current, unrestricted license with no previous or pending actions.
    - ii) Relevant training or experience
    - iii) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.
    - iv) Current comparable clinical privileges at another institution.
    - v) Response from NPDB-HIPDB PDS registration with no match.
    - vi) Response from FSMB with no reports.
    - vii) Other criteria required by the organized medical staff bylaws
    - viii) No current or previously successful challenges to licensure.

- ix) No history of involuntary termination of medical staff membership at another organization.
  - x) No voluntary limitation, reduction, denial, or loss of clinical privileges.
  - xi) No final judgment adverse to the applicant in a professional liability action.
- B. A completed application must be submitted within three calendar days of temporary privileges being granted and credentialing completed.
2. Expedited Process:
- A. The credentialing process cannot begin until the Practitioner completes and submits the entire application including VetPro.
- B. The Facility:
- i) Verifies education and training;
  - ii) Verifies one active, current, unrestricted license from a State, Territory, or Commonwealth of the United States or the District of Columbia;
  - iii) Receives confirmation on the declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;
  - iv) Queries licensure history through the Federation of State Medical Boards (FSMB) Physician Data Center and receives a response with no report documented;
  - v) Receives confirmation from two peer references who are knowledgeable of and confirm the physician's competence, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges, or who would have reason to know the individual's professional qualifications.
  - vi) Verifies current comparable privileges held in another institution; and
  - vii) Receives a response from NPDB-HIPDB PDS registration with no match.
  - viii) Verifies that there are no current or previously successful challenges to licensure.
  - ix) Verifies that there is no history of involuntary termination of medical staff membership at another organization.
  - x) Verifies that there is no history of voluntary limitation, reduction, denial, or loss of clinical privileges.
  - xi) Verifies that there is no history of final judgments adverse to the applicant in a professional liability action.
- C. A delegated subcommittee of the Medical Executive Board, consisting of at least two voting members of the full committee, recommends appointment to the medical staff.

- D. The recommendation by the delegated subcommittee of the Medical Executive Board must be acted upon by the Facility Director.
- E. Full credentialing must be completed within 60 calendar days of the date of the Director's/Governing Body's signature and presented to the Medical Executive Board for ratification.
- F. 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 through routine processes by the Medical Executive Board.

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

- 3. **Emergency Care:** Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.
- 4. **Provisional Clinical Privileges:** Provisional Privileges are time-limited privileges that may be requested by a provider when the provider has not fully met all criteria.

A. Provisional privileges may be considered when:

- 1) a provider has received initial training to perform a new procedure but has not fully developed the required technical skills;
- 2) a provider has not met the required number of cases to be granted full privileges;
- 3) a provider is new to the facility and the provider's skill level is not known, particularly for high risk/low volume procedures.

B. Provisional privileges may be performed without direct supervision, however during this time the provider will practice under the direction of another provider with full privileges for those privileges granted as provisional. The fully privileged provider will monitor the performance of the provider with provisional privileges throughout the designated provisional period. The provider with provisional privileges will be expected to meet the competency requirements for full privileges before the completion of the provisional period.



**PLEASE NOTE:** *In some situations, especially related to advances in technology or new procedures in the facility (e.g., robotic-assisted surgery), a fully privileged practitioner may not be available on site to provide direction to a provider with provisional privileges. In such cases, the Medical Executive Board will review a proposal from the requesting practitioner and/or Service Line to determine whether the Institutional Review Board and Human Studies Committee should regulate the procedure as research. Such proposals should include a summary of the procedure or technology, an assessment of its risks and benefits compared to other treatment options, and a justification for performance of the procedure.*

C. Upon recommendation from the sponsoring Service Line, the Medical Executive Board will review and determine whether the requirements for provisional privileges for each specific procedure have been met. In general, these requirements will include:

- 1) The provider is fully privileged to perform standard procedures for the disease being treated; if applicable (e.g. a surgeon should be fully privileged to perform an open operation that corresponds to a minimally invasive surgical procedure).
- 2) The provider received formalized training at another institution, if available.
- 3) The Medical Executive Board will designate who should be assigned to monitor and report outcomes to assure patient safety.
- 4) The Medical Executive Board will determine the number of cases to be performed by the provider to be eligible for full privileges that will be based upon the complexity of the procedure, experience of the provider with related procedures, and procedural risk profile.
- 5) A contingency plan for management of complications will be presented.

D. The Medical Executive Board may grant provisional privileges for a specified period of time. The time period may range from 3 months but is not to exceed 12 months. Provisional privileges up to 12 months may be needed in specialized areas where the caseload may be low to achieve competency within a shorter period of time.

5. Supervised Clinical Privileges: Supervised Clinical Privileges are time-limited privileges that may not be performed independently by a provider and require the participation of another provider with full privileges during the delivery of care. Supervised privileges may be granted for a specified period of time from 6 months but not to exceed 24 months while a provider is learning how to perform a new procedure or is developing a new skill. The level of supervision provided for supervised privileges will vary and will be determined on an individual case-by-case basis. The level of supervision may include one or more of the following:
  - A. direct hands-on training;
  - B. offering guidance or direction during performance of the procedure;

- C. review of medical record documentation; or,
- D. monitoring procedure outcomes.

**6. Disaster Privileges:** Implemented when circumstances of disaster(s), in which the emergency management plan has been activated, and the medical center is unable to handle the immediate patient needs:

- A. In the event of the implementation of the organization-wide disaster management plan, Disaster Privileges may be approved by the Director/Chief of Staff/ or Designee if it is determined that it is not possible to handle the influx of patients with the existing Practitioners. Any of the following will be accepted as credentials verification process for emergency volunteers to provide patient care in the facility:
  - i) Evidence of a current license (pocket card sufficient) to practice.
  - ii) And one of the following:
    - (a) A current medical facility photo ID card.
    - (b) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
    - (c) Identification that the individual has been granted authority to render patient care in emergency circumstances by a Federal, state, or municipal entity.
- B. The documentation will serve as credentials verification for a period not to exceed ten (10) calendar days or length of the disaster, whichever is shorter. Primary source verification of licensure will be obtained within seventy-two (72) hours after the disaster is under control, or as soon as possible in extraordinary circumstances.
- C. In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the 10 calendar days or the length of the declared disaster, whichever is shorter, noted in paragraph b above, the Practitioner must be converted to Temporary Privileges in accordance with VHA Handbook 1100.19, Credentialing and Privileging, for a period not to exceed 60 working days.
- D. An assigned, appropriately credentialed and privileged physician oversees the professional practice of each volunteer, Licensed Independent Practitioner, Mid-Level Practitioner, and Allied Health Practitioner.
- E. The quality of the care and service rendered by each volunteer Practitioner with Disaster Privileges must be evaluated at the end of 72 hours and a determination made as to whether or not the Practitioner will be permitted to continue providing services.
- F. The practitioner will be identified as a volunteer by a Medical Management armband.

- G. The standard credentials verification process will be used. The provider will be appointed by Human Resources as without compensation (WOC) and this appointment will provide liability coverage under the Federal Tort Claim Act.
- H. In an emergency situation, any medical staff member with clinical privileges may provide any type of patient care necessary as a life-saving measure or to prevent serious harm (regardless of his/her privileges) if the care, treatment and services provided is within the scope of the individual's license.

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

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

**8. Deployment and Activation Privilege Status:** In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment. **NOTE:** *No step in this process should be a barrier in preventing the Practitioner from returning to the Facility in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.*

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

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

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

9. It will be the responsibility of the Center for Organ Recovery and Education (CORE) to credential and privilege the non-donor hospital personnel who participate in organ, tissue and eye recoveries. The credentialing and privileging will be in compliance with the standards established by the Joint Commission.

10. It will be the responsibility of the contractor to credential and privilege personnel who have been contracted to provide patient care services off-site. This credentialing and privileging will be in compliance with the standards established by the Joint Commission as defined in the contract. The only exception will be Community Based Outpatient Clinic (CBOC) providers. CBOC providers will be credentialed and privileged by the VAPHS since these providers have direct access to the veterans' computerized patient record system (CPRS).

11. Visiting professors who are not involved in direct, hands-on patient care and who are mainly observing patient care, do not need to be credentialed and privileged.

[Please note: all visiting professors who are involved in direct, hands-on patient care (e.g. learning new medical procedures, surgical techniques, etc.) must be fully credentialed and privileged by the VAPHS.

12. Medical staff who are in an administrative, education, or research role and are not involved in direct, hands-on patient care must be credentialed but do not need to be granted clinical privileges. Medical Staff in these roles may have access to medical records of patients in order to fulfill the obligation of their position.

### ARTICLE IX INVESTIGATION AND ACTION \*

1. Request for Investigation: Whenever the behaviors, activities and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Facility Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct, which constitute the grounds for the request. The Chief of Staff promptly notifies the Director in writing of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. **NOTE:** *If the person under review, is an employee then the processes must also follow VA Directive 5021 - Management of Employees (Appendix A pages 2-9).*
2. Fact Finding Process: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article IX, a fact finding process will be implemented. This fact-finding process should be completed within 30 days or there needs to be documentation as to why that was not possible. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities and/or professional conduct the Practitioner

are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff or to represent Professional Misconduct, Disruptive Behavior, or Inappropriate Behavior, as defined in these Bylaws, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the Medical Staff Professional Standards Board.

3. Review by Medical Staff Professional Standards Board: The Medical Staff Professional Standards Board (MSPSB) investigates the charges and makes a report of the investigation to the Medical Executive Board within 14 days after the MSPSB has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the MSPSB to discuss, explain or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation by the MSPSB is an administrative matter and not an adversarial Hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations reported to the MEB.
4. MEB Action: Within 14 days after receipt of a report from the MSPSB, the MEB acts upon the request. If the action being considered by the MEB involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the MEB prior to the committee's action on such request. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. A record of such proceeding is made by the MEB.
  - a. The MEB may reject or modify the recommendations; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommend that the Practitioner's staff membership be suspended or revoked.
  - b. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.
  - c. Reduction of privileges may include, but not be limited to, functioning under supervision<sup>1</sup>, restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.
  - d. Revocation of privileges refers to the permanent loss of clinical privileges.

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<sup>1</sup> See the definition of Proctoring for an explanation of the difference between proctoring and supervision.

5. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, or portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by Facility Director.
  - a. The Chief of Staff convenes the MSPSB to investigate the matter, meet with the Practitioner if requested and make a report thereof to the MEB within fourteen (14) days after the effective date of the Summary Suspension.
  - b. Immediately upon the imposition of a Summary Suspension, the Service Line Vice President or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.
6. Automatic Suspension of Privileges: An Automatic Suspension occurs immediately upon the occurrence of specific events.
  - a. The medical staff membership and clinical privileges of any Practitioner with delineated clinical privileges shall be automatically suspended if any of the following occurs:
    - i) The Practitioner is being investigated, indicted or convicted of a misdemeanor or felony that could impact the quality and safety of patients.
    - ii) Failure on the part of any staff member to complete medical records in accordance with system policy will result in progressive disciplinary action to possible indefinite suspension.
    - iii) The Practitioner is being investigated for fraudulent use of the Government credit card.
    - iv) Failure to maintain the mandatory requirements for membership to the medical staff.
    - v) Patient abuse including mental, physical, sexual, and verbal abuse.
    - vi) Any action or behavior that conflicts with patients' rights identified in VA Regulation 38 CFR 17.34A.
    - vii) Intentional omission of care.
    - viii) Willful violations of patient's privacy.
    - ix) Intimidation, harassment, or ridicule of a patient.
    - x) Willful physical injury.
    - xi) Substance/alcohol abuse while performing duties.
    - xii) Incompetence in performing granted privileges.
    - xiii) Expiration of license.
  - b. The Chief of Staff convenes the MSPSB to investigate the matter and make a report thereof to the MEB within fourteen (14) days after the effective date of the Automatic Suspension.

- c. Immediately upon the occurrence of an Automatic Suspension, the Service Line Vice President or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.
  - d. If there are more than three automatic suspensions of privileges in one calendar year, or more than 20 days of automatic suspension in one calendar year, a thorough assessment of the need for the Practitioner's services must be performed and documented and appropriate action taken.
  - e. The Director will revoke the suspension upon recommendation of the Medical Executive Board.
  - f. Individuals appointed under authority of 38 U.S.C. 4114 may be terminated when this is determined to be in the best interests of the VA in accordance with provisions of MP-5, Part II, Chapter 9, and VHA Supplement, without regard to the procedural requirements indicated above.
7. Union Representation: When the Practitioner is a union member, he/she has the right to representation in the interview processes described in paragraphs 1 through 6 of this Article IX.
8. Actions Not Constituting Corrective Action: The MSPSB will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:
- a. The appointment of an ad hoc investigation committee;
  - b. The conduct of an investigation into any matter;
  - c. The making of a request or issuance of a directive to an applicant or a Practitioner to appear at an interview or conference before the Credentials Committee, any ad hoc investigating committee, the Chief of Staff, or any other committee or sub-committee with appropriate jurisdiction in connection with any investigation prior to a proposed adverse recommendation or action;
  - d. The failure to obtain or maintain any other mandatory requirement for Medical Staff membership;
  - e. The imposition of proctoring or observation on a Medical Staff member which does not restrict clinical privileges or the delivery of professional services to patients;
  - f. The issuance of a letter of warning, admonition, or reprimand;
  - g. Corrective counseling;
  - h. A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education; or
  - i. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.



## ARTICLE X FAIR HEARING AND APPELLATE REVIEW \*

### 1. Reduction of Privileges:

- A. Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:
  - i) A description of the reason(s) for the change.
  - ii) A statement of the Practitioner's right to be represented by counsel or a representative of the individual's choice, throughout the proceedings.
- B. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff's written notice of intent. The Practitioner must submit a response within 10 workdays of the Chief of Staff's written notice. If requested by the Practitioner, the Chief of Staff may grant an extension for a brief period, normally not to exceed 10 additional workdays except in extraordinary circumstances.
- C. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the Practitioner disagrees with the Director's decision, a hearing may be requested. The Practitioner must submit the request for a hearing within five (5) workdays after receipt of decision of the Director.

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

- a. The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.
- b. During such hearing, the Practitioner has the right to:
  - i. Be present throughout the evidentiary proceedings.
  - ii. Be represented by an attorney or other representative of the Practitioner's choice. **NOTE:** *If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses.*
  - iii. Cross-examine witnesses.

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

3. In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.
4. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.
  - a. The panel's report, including findings and recommendations, must be forwarded to the facility Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.
  - b. The facility Director must issue a written decision within 10 workdays of the date of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision must indicate the reason(s). The signature of the facility Director constitutes a final action and the reduction is reportable to the NPDB.
  - c. If the Practitioner wishes to appeal the Director's decision, the Practitioner may appeal to the appropriate VISN Director within 5 workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.
  - d. The VISN Director must provide a written decision, based on the record, within 20 workdays after receipt of the Practitioner's appeal.

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

5. The hearing panel chair shall do the following:
  - A. Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
  - B. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.
  - C. Maintain decorum throughout the hearing.
  - D. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
  - E. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.

- F. Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.
  - G. Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.
6. Practitioner Rights: The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.
- A. The panel will complete its review and submit its report within 15 workdays of the date of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.
  - B. The Director will issue a written decision within 10 workdays of the day of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.
  - C. The Practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.
  - D. The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the Practitioner's appeal. The decision of the VISN Director is not subject to further appeal.
  - E. A Practitioner who does not request a review panel hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN Director within five workdays after receipt of the Director's decision.
  - F. The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.
  - G. If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, if greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.
7. Revocation of Privileges:
- A. Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures.
    - i) In instances where revocation of privileges is proposed for permanent employees, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations.

- ii) For probationary employees appointed under 38 U.S.C. 7401(1) and 38 U.S.C. 7405, the proposed revocation will be combined with probationary separation procedures, which constitutes an automatic revocation as contained in VA Handbook 5021 Employee/Management Relations.
  - B. Revocation procedures will be conducted in a timely fashion. If discharge, separation during probation, or termination of appointment is not proposed, revocation of clinical privileges may not occur. Even though a revocation of privileges requires removal from both employment and appointment to the medical staff, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. For example a surgeon's privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.
8. Reporting to the National Practitioner Data Bank<sup>2</sup>:
- A. Tort ("malpractice") claims are filed against the United States government, not individual Practitioners. There is no direct financial liability for named or involved Practitioners. Government attorneys (Regional Counsel, General Counsel, U.S. Attorney) investigate the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.
  - B. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioners should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.
  - C. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist regional and general counsel in defending the case and in decisions concerning denial or settlement.
  - D. Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff's case when a tort claim settlement is submitted for review.
  - E. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physician and Dentists after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical

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<sup>2</sup> Reference VHA Handbook 1100.17.

privileges. The reference for this is 38 CFR part 46.4 The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension if greater than 30 days will be reported.

9. Reporting to State Licensing Boards: VA has a responsibility to report to state licensing boards appointed or suspended members of the Medical Staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.
10. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.
11. Termination of Appointment: Termination of medical staff appointments will be accomplished in conjunction with, and follow procedures for, terminating appointments of practitioners set forth in MP-5, Part II, Chapters 4, 8 and 9 and MP-5, Part I, Chapters 752, 315 and 316.

#### **ARTICLE XI RULES AND REGULATIONS \***

1. As may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to identify the level of clinical practice that is required of each member of the Medical Staff and of all others with delineated clinical privileges or practicing under a Scope of Practice, Medical Staff Rules and Regulations may be adopted. Rules and Regulations may be adopted, amended, repealed or added by a majority vote of the members of the Medical Executive Board present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. Medical Staff Rules and Regulations must be approved by the Director.
2. This healthcare system functions under Federal law and policies promulgated by the Veterans Health Administration. These rules and regulations are effective at date of issue by VA Headquarters and all Medical Staff must comply with these rules and regulations.
3. In addition, there are VAPHS policies which, in effect, constitute local rules and regulations governing the medical staff and shall be a part of these bylaws, subject to review by the Medical Executive Board at the request of any staff member. Such

amendments shall become effective when approved by the Director and all Medical Staff must comply with VAPHS policies.

4. Self-Governance Actions

- a. Competence and performance are monitored through an annual appraisal of performance and a biennial appraisal of clinical privileges. Continuing education is an adjunct to maintaining clinical skills and current competence. Hospital sponsored educational activities will be offered and related to the type and nature of care, treatment and services offered by the hospital and the findings of performance improvement activities. The MEB will assist with prioritization of hospital-sponsored continuing education as needed.
- b. Individual participation in continuing medical education is required at the time of reprivileging. The VAPHS minimum requirement for continuing medical education is 40 hours in the field of practice during a two-year re-privileging cycle which must include 20 hours category I CME. The continuing education requirement may be met by formal courses or training; specialty conferences; on-line courses; participation in Grand Rounds, journal clubs, etc.

***PLEASE NOTE:*** *The required hours for continuing education may be prorated only during the initial credentialing and privileging cycle. When a provider is initially appointed, the provider will be placed on a two-year cycle based on their birthday month. In this situation the provider's initial cycle may be shortened by a few months and the required hours for continuing education may be reduced (or prorated) due to the shortened credentialing and privileging cycle.*

- c. Each provider of services for patients presenting with Acute Coronary Syndrome (Acute MI) is required to complete a minimum of 2 Continuing Medical Education (CME) Credit hours per year.

**ARTICLE XII AMENDMENTS \***

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from MEB. Changes to the bylaws are amended, adopted and voted on by the Organized Medical Staff as a whole and then approved by the Director. The Bylaws are amended and adopted by a majority vote of the members present.
2. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
3. All changes to the Bylaws require action by both the Organized Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.

4. Changes are effective when approved by the Director.

**ARTICLE XIII ADOPTION \***

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

RECOMMENDED

/S/ *	12/1/2010
_____ Ali F. Sonel, M. D., FACC, FACP Acting Chief of Staff	_____ Date

APPROVED

/S/ _____	12/2/2010
_____ Terry Gerigk Wolf, FACHE Director	_____ Date

\* **A signed hard copy is on file in the Chief of Staff's office.**

## **MEDICAL STAFF RULES**

### **1. GENERAL**

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

### **2. PATIENT RIGHTS \***

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



- viii) Access to information about patient rights, handling of patient complaints.
  - ix) Participation of patient or patient's representative in consideration of ethical decisions regarding care.
  - x) Access to information regarding any human experimentation or research/education projects affecting patient care.
  - xi) Personal privacy and confidentiality of information.
  - xii) Action by a legally authorized person to exercise a patient's rights if a patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or unable to communicate his/her wishes.
  - xiii) Authority of the Chief of Staff (or Acting Chief of Staff or designate) to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available).
  - xiv) Foregoing or withdrawing life-sustaining treatment including resuscitation.
  - xv) Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.
  - xvi) Information related to any billing for health care services.
- B. Patients facilitate better treatment outcomes for themselves when they are responsible for participating in their care by:
- i) Providing full information to their physician including all symptoms, previous illnesses and medications and reporting any changes in their condition;
  - ii) Asking questions to clarify what they do not understand;
  - iii) Being available for medical rounds and distribution of meals and medications when an inpatient;
  - iv) Following instructions on medications and other treatments as prescribed and informing their provider when they are having difficulty following advice.
  - v) Informing administrative staff of any changes in address, phone numbers or insurance information and meeting all financial obligations;
  - vi) Understanding all discharge instructions and keeping scheduled follow-up appointments.
  - vii) Carrying some personal identification at all times particularly medic alert identification.
- C. Patients are responsible for following rules, regulations and staff instruction concerning safety and conduct to enhance their own care and that of other patients, including:
- i) Treating other patients, staff and volunteers with dignity, courtesy and respect, and seeking to resolve complaints and requesting assistance in doing so as needed;

- ii) Observing smoking regulations, visiting hours and controlling noise;
  - iii) Safeguarding clothing, money and personal possessions and respecting the property of others. Refraining from bringing firearms, alcohol or non-prescribed medications into the medical center;
  - iv) Alerting staff when another patient is having difficulty and avoiding interference in the treatment of other patients, especially in emergencies;
  - v) Protecting their privacy by being properly clothed; and
  - vi) Paying any bills related to care promptly.
- D. When a patient fails to act responsibly by not adhering to the rules and regulations of the VAPHS, the physician may consult with the COS to determine appropriate action up to and including administrative discharge.
- E. Living Will, Advance Directives, and Informed Consent
- i) Competent patients have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.
  - ii) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending physician in consultation with, as appropriate, other members of the treatment team (38 USC sections 7331).
  - iii) With respect to the documentation of decision making concerning life-sustaining treatment, the following information, at a minimum, will be documented in the progress notes by the attending physician: The patient's diagnosis and prognosis; an assessment of the patient's decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.
  - iv) Competent patients will be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning life-sustaining treatment will be honored, and will be documented in the medical record.
  - v) Advance Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any competent patient may

execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a declarant at any time.

- (a) An advance directive is a written statement made by a competent patient which states preferences regarding medical treatment including but not limited to, life-sustaining treatments or which designates a surrogate decision-maker who will make decisions regarding medical care in the event the patient is unable to do so. The directive may include a Living Will, Durable Power of Attorney for Healthcare, treatment preferences or valid relevant state-authorized advance directives. All orders for advance directive will follow VAPHS policy, which will include:
- (1) An oral statement made by a patient to a VA clinical employee and documented in writing concerning the patient's wishes regarding life-sustaining treatment, or
  - (2) A patient's written statement on appropriate VA forms that sets forth the patient's wishes regarding life-sustaining treatment, or
  - (3) A "state-authorized advance directive", which is a patient's written statement expressing wishes regarding life-sustaining treatment, which is not made on a VA form, but whose validity is to be determined pursuant to the applicable state law.
    - (i) The physician, family members and/or significant others may be involved in the decision making when the patient is incompetent to do so. In situations where an incompetent patient has no surrogate and the attending physician feels that a DNR order is appropriate, consultation should be undertaken with the Chief of Staff to determine the appropriate course of action (i.e. Ethics Consultation).
    - (ii) Mechanisms for reaching decisions about DNR and withholding of resuscitative services, including mechanisms to resolve conflicts in decision making and documentation requirements are fully discussed in healthcare system policies. After it has been determined that a DNR order is appropriate and the foregoing requirements have been met, a dated and timed order must be entered in the patient's medical record by the attending physician. In an emergent situation if the attending physician is not available, the order may be entered by a house officer after discussion with the attending physician. The attending physician must sign the DNR order within 24 hours. Documentation in the medical record should include the following information: summary of the patients medical

condition, assessment of the patients decision-making capacity, patient's/surrogate's wishes regarding resuscitation and other life-sustaining treatment, consultation with other physicians and healthcare providers, and delineation of a supportive care plan.

- vi) Substituted Judgments: The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:
- (a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.
  - (b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.
  - (c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the attending physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Advisory Committee or similar body, or Chief of Staff.

### 3. RESPONSIBILITY FOR CARE\*

#### A. Conduct of Care

- i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff. Care is delivered primarily to an adult and geriatric patient population by qualified and competent staff. Management and coordination of a patient's care, treatment and services is the ultimate responsibility of a designated attending physician. Nurse practitioners and physician assistants are associate providers of care with a defined scope of practice, but the physician maintains ultimate responsibility for the patient's care. Treatment and procedures will be provided by competent practitioners as designated by their clinical privileges/scope of practice. Invasive procedures performed by a Nurse Practitioner/Physician Assistant will be appropriately supervised by a physician.
  - (a) The attending Staff Physician is responsible for the preparation and completion of a complete medical record for each patient. This record shall include an updated problem list, identification data, chief complaints, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathological findings, progress notes, doctor's discharge instructions sheet, including condition on discharge (discharge note) and final diagnosis, and final summary.
  - (b) The staff physician responsible for the patient must sign the admission note if it is prepared by a resident, intern, or Mid-Level Practitioner, or make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and findings" or make whatever comments he/she thinks the case warrants, or prepare a complete admission within seventy two (72) hours of admission to the CLC. In the event a resident, intern, or Mid-Level Practitioner prepares an admission workup, all will be retained, but the official workup will contain the responsible Medical Staff physician's approval signature. All resident documentation will follow procedures outlined in the VHA Handbook 1400.1, Resident Supervision.
  - (c) There is communication among all practitioners involved in a patient's care, treatment, and services. Care is planned and provided in an interdisciplinary, collaborative manner by qualified competent staff. Long term care psychiatry and substance abuse will have documentation evident of multidisciplinary planning for all patients' treatment modalities.
  - (d) The Department of Veterans Affairs is responsive to a physician's cultural values, ethics, and religious beliefs and the needs of patient care. A physician may request not to participate in a particular patient's care if it directly conflicts with those beliefs or personal standards.

- (1) Requests for such reassignments will be made in writing to the supervisor prior to realignment of responsibility, and will include specific values, ethics, or religious beliefs involved.
  - (2) The staff member making such a request for reassignment is responsible to realign duties and exchange a particular aspect of care for a given patient with a competent, qualified co-worker.
  - (3) Under no circumstances will the request be granted if the patient's treatment is negatively affected.
- (e) Food and nutrition products are administered only on the prescription or order of a Medical Staff member, an authorized house staff member, or other individual who has been granted authority to write such prescriptions or orders, within their scope of practice.
  - (f) Progress note entries should be identified as to the type of entry being made, (e.g., Resident Note, Attending Note, Off Service Note, etc.). The Attending Note must be signed by the Attending physician.
  - (g) Progress notes will be written by the Practitioner at least once daily on all acutely ill patients. Progress notes are written for all patients seen for ambulatory care by the medical staff.
  - (h) Evidence of required supervision of all care by the attending physician shall be documented in the medical record, the frequency of notes dependent upon the severity of the illness of the patient. It is a cardinal principle that responsibility for the care of each patient lies with the staff physician to whom the patient is assigned and who supervises all care rendered by residents.
  - (i) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written or, at minimum, countersigned by the attending physician in the patient's medical record. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the Facility staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.
  - (j) Patients will not be transferred out when the Facility has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer only after authorization is given by the appropriate provider as defined in facility policy.
  - (k) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and across Departments and Services and between all staff members who have clinical privileges.

- (l) There is to be a comparable level of quality of surgical and anesthesia care throughout the Facility.

B. Emergency Services

- i) The VA Pittsburgh Healthcare System UD Division is capable of providing emergency services (except trauma care) as designated by written policies and procedures. The HD Division has been designated as a Psychiatric Evaluation and Referral Center (PERC) for evaluation of psychiatric emergencies.
- ii) A physician is available in-house to provide emergency services 24 hours per day, seven days per week.
- iii) Evaluation of applicants regarding emergent/urgent needs and follow-up treatment or referral is done by a qualified physician.

C. Admissions

- i) Admissions A veteran will not be admitted to the healthcare system against his/her wishes unless s/he has been detained when under Sections 302, 303, 304, or 305 of the PA Mental Health Procedures Act of 1976, or under the applicable commitment law of the state of residence.
- ii) Admitting privileges are granted to physicians, oral surgeons, and dentists. The admitting service line will assign an attending physician who is responsible for the total medical care and treatment of the patient and for prompt and accurate medical record completion. Except in an emergency, no patient shall be admitted until a provisional diagnosis has been recorded in the medical record by the admitting provider.
- iii) Entry and Identification of the Code Status Order
  - (a) A Code Status Order and a Code Status Note should be entered in CPRS by the attending physician on admission. If the patient is in an acutely deteriorating condition and the attending physician is not physically present in the Medical Center, a resident physician or the treating team may discuss Code Status with the patient or his/her surrogate decision-maker, as appropriate and validate the Code Status with the attending physician by phone.
  - (b) The attending physician is responsible for signing the Code Status Note within 24 hours. Once signed, the Code Status will remain in effect and visible as a CWAD throughout the patient's hospitalization.
  - (c) If the code status changes, a new Code Status Order will be entered with an addendum to the Code Status Note signed by the attending physician detailing the circumstances of the change. The most recent Code Status will be the official code status in the CWAD section of the cover sheet of CPRS.
- iv) A complete History and Physical (H&P) Examination must be performed by a qualified physician within 24 hours of inpatient admission except for

patients readmitted within 30 days of the last admission to this healthcare system. In an emergency when there is no time to record the complete H&P, a progress note describing a brief history and appropriate physical findings and the pre-operative diagnosis must be recorded in the medical record before surgery.

- v) The Dental Program will ensure that a dental screen is completed on patients admitted to the healthcare system in accordance with VA regulations. Patients admitted for dental procedures will receive the same medical history and physical examination as patients admitted for other services. This examination is to be completed by a physician member of the medical staff but the physician need have no further involvement in patient management unless a significant medical problem exists at the time of admission or arises during the course of hospitalization. Treatment performed by the Dental Program will be made a part of the patient's permanent medical record.
- vi) Reassessment of the patient will occur on a daily basis in acute care or when there is a change in the patient's condition. Clinical services directly involved with patient care activities will define in their policies and procedures the information required for patient assessment/reassessment.
- vii) Procedures: Medical staff is responsible for the medical care and treatment of all patients, prompt completion and accuracy of the medical record, any special instructions, and transmittal of reports on the condition of a patient to the referring practitioner and family of the patient.
- viii) Tests
  - (a) Appropriate lab work will be performed on inpatients as determined by the admitting physicians.
- ix) Areas of restricted admission
  - (a) Criteria must be met for admission to areas providing specialty care services.
  - (b) The Communication Center is responsible for utilizing admission criteria when coordinating bed assignments for patients within the VAPHS.
- x) Patients admitted with a medical or surgical diagnosis who also have an active psychiatric disorder will be co-managed with psychiatry service and vice versa.

#### D. Transfers

- i) It is the responsibility of the Communication Center to screen requests for care. The medical center shall accept patients for care and treatment who are medically and legally eligible as defined by law and by the Department of Veterans Affairs and who require treatment for which this facility has the means to provide. For humanitarian reasons, in cases that represent a medical emergency, medical care will be rendered until such time that the



patient's condition is stable enough either to be discharged from care or to be transferred safely to another health care facility.

- ii) Patients will not be transferred to other facilities when the healthcare system has the means to provide adequate care.
- iii) When a patient must be transferred, the facility receiving the patient must be able to meet the patient's needs and provide consent to accept the patient. The healthcare system must ensure that the patient is stable for transfer, safe transfer of the patient is arranged, and all pertinent medical information accompanies the patient.
- iv) Transfers to and from Critical Care Units are the Unit director's responsibility with attending physician consultation.
- v) The Physician transferring the patient (e.g. Attending, Resident, MOD) is responsible for contacting the patient's next of kin when the patient requires a higher level of care due to a change in medical condition (e.g. transfer from HD to UD).

#### E. Consultation

- i) Consultation: Except in an emergency, consultation with a qualified physician is desirable when in the judgment of the patient's physician:
  - (a) The patient is not a good risk for operation or treatment,
  - (b) The diagnosis is obscure, and/or
  - (c) There is doubt as to the best therapeutic measures to be utilized.

These judgments rest with the attending physician responsible for the care of the patient. It is the duty of the medical center staff, through its Service Line Vice Presidents and Chief of Staff, to see that members of the staff make appropriate use of consultation.

- ii) Consultant: A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff and the Professional Standards Boards on the basis of an individual's training, experience, and competence.
- iii) Inpatient Consultations: Inpatient consultations are provided upon request and should be completed within one (1) day of the request, (unless it is an emergency,) and include an examination of the patient and a review of the medical record.
- iv) Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

- v) Responsibility for Requesting Consultations: The patient's physician, through the Chiefs of Services, shall make certain that members of the staff do not fail in the matter of providing consultation as needed.
  - vi) Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.
- F. Protective security may be required in the care of combative or emotionally disturbed patients.
- G. Restraint and/or seclusion may be used as a therapeutic treatment modality in situations when a patient is at significant risk of harming him/herself or others, and less restrictive interventions have been unsuccessful or inappropriate. Restraints and/or seclusion orders must be time limited. P.R.N. orders are not permissible. The time limits for orders include:
- i) acute illnesses: 24 hours
  - ii) behavioral health needs: 4 hours
  - iii) geriatric and extended care needs: 24 hours to 30 days, as use proceeds over time the physician must document the indications/justifications for restraint usage and specify the type of restraint required. More specific information regarding patient observation, orders, and documentation may be found in healthcare system policy
- H. An emergency commitment may be initiated when the physician, based upon personal observation, believes that the veteran is severely mentally disabled so as to pose a clear and present danger to oneself or others.
- I. Patients with chronic impaired mentation due to drugs, alcohol or psychiatric problems will receive ongoing care at Highland Drive. Interdisciplinary treatment plans will be initiated for implementation of psychiatric or substance-abuse services. The treatment will be reviewed, updated and individualized for each patient, and will include the family as appropriate.
- J. An Incident Report is to be completed when an inpatient or outpatient is involved in an incident that either has harmed or has the potential of causing harm to the patient. The physician is responsible for examining the patient and documenting the medical evaluation.
- K. A sentinel event is defined as an incident resulting in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition (e.g. suicide, rape, hemolytic transfusion reaction and surgery on the wrong patient or wrong body part).
- L. An unplanned clinical occurrence is an incident that results in hospitalization or increased hospital stay for more than observation (e.g. physical or sexual assaults, suicide attempts, patient abuse, missing patients, fires, falls and medication errors).

- M. A root cause analysis will be performed to determine more distinct reasons for sentinel events and unplanned clinical occurrences.
- N. Surgery is performed only after a history, physical examination, any indicated diagnostic tests, and documentation in the patient's medical record has been appropriately completed. In emergency a situation in which there is inadequate time to complete the H&P before surgery, a brief note, including the pre-op diagnosis is recorded before surgery.
- O. The VAPHS does not provide chiropractic care on-site. Chiropractic services are available by referral. The outpatient fee basis program may be used to provide chiropractic services by a community chiropractor.
- P. Discharge Planning: Discharge planning is initiated as early as a determination of need is made.
  - i) Discharge planning provides for continuity of care to meet identified needs.
  - ii) Discharge planning is documented in the medical record.
  - iii) Criteria for discharge are determined by the Multidisciplinary Treatment Team.
  - iv) Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.
  - v) Discharge planning is required to ensure the patient's discharge is as soon as hospitalization is no longer required.
- Q. Discharge
  - i) Patients shall be discharged from the Facility only upon the written order of the physician and the discharge summary will be dictated no later than the day of discharge. At time of dictating the final summary, the responsible member of the Medical Staff shall review the medical record to ensure that documents therein pertain to the patient and contain accurate data. The record shall be completed within thirty (30) days of the discharge of the patient. The physician or dentist shall complete his/her portion of the record within thirty (30) days, including authentication.
  - ii) The assessment and plan for discharge by the treatment team will be approved by the physician, will be based on the patient's medical and psychosocial needs, and will emphasize return to the community at the optimal level of functioning. Documentation should reflect the assessment, treatment, patient/family involvement, patient education, referrals, follow-up and outcome. The patient's interdisciplinary treatment team before discharge will evaluate any problems (e.g. family concerns, home care, change in physical/mental status, social needs) that may delay a discharge.
  - iii) Discharge from the Critical Care Units is based on approved clinical criteria.

- iv) Discharge from Post Anesthesia Recovery is based upon the order of the Anesthesiologist. The discharging anesthesiologist's name must be recorded in the patient's medical record.
- v) Patients from Ambulatory Surgery/Procedure Unit can be discharged based upon order of Licensed Independent Practitioner familiar with the patient or when the Practitioner is not available, based on relevant medical staff approved criteria. The Practitioner's name is recorded in the patient's medical record.
- vi) An unplanned discharge may occur when a competent patient chooses to terminate his/her hospitalization and refuses any further examination or treatment that is medically indicated. The physician is responsible for informing the patient of the inherent clinical risks involved in the unplanned discharge and the events/reason for leaving (if known) should be documented on the Discharge Against Medical Advice Form. The form must be signed by the provider and the patient and is to be a part of the permanent record

#### R. Autopsy

- i) Autopsy services are provided by VAPHS when a patient dies while an inpatient at the VAPHS or while under the immediate care of the VAPHS such as during an outpatient or emergency care visit, or during an ambulatory care procedure. The availability of autopsies will be made known to the family of each decedent and the medical staff will attempt to secure authorization for autopsy examinations in cases where such an examination may clarify the cause of death, be of general educational benefit, and is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within the Facility. The VA Pittsburgh Healthcare System will strive to achieve an autopsy rate of 3% as directed by VHA. It is especially important that autopsies be obtained in the following cases:
  - (a) Deaths in which autopsy may explain unknown or unanticipated medical complications.
  - (b) When the cause of death is not known with certainty on clinical grounds.
  - (c) An autopsy may help to allay the concerns of the family or public regarding the death and to provide reassurance to them regarding the same.
  - (d) Unexpected or unexplained deaths occurring during or following and medical, surgical and dental diagnostic or therapeutic procedure.
  - (e) Death of patients who participated in clinical trials.
  - (f) Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction.

- (g) Natural deaths that are subject to, but waived by, forensic medical jurisdiction, e.g.:
  - (1) Person dead on arrival to hospital
  - (2) Death within 24 hours of admission.
  - (3) Death in which patient sustained or apparently sustained an injury while in the hospital.
- (h) When it is believed that autopsy would disclose a known or suspected illness that may have a bearing on the survivors or recipients or organs.
- (i) Deaths known or suspected to have resulted from environmental or occupational hazards.
- ii) Autopsy should be avoided in patients with known or seriously suspected Creutzfeldt-Jacob Disease.
- iii) There will be legal authorization by the next of kin or legally authorized individual for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-155. Whenever possible, the physician responsible for the care of the patient at the time of death will be designated to request permission from the next of kin to perform an autopsy.
- iv) Autopsy consent may be voice recorded, a witnessed telephone call, or direct consent in writing. Documentation of the request for autopsy and outcome of the request will be entered into the medical record. A staff pathologist shall perform all autopsies.
- v) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.155 and JAHVH HPM 11-31 Autopsy Services (which includes Criteria for assignment to medico-legal status).
- vi) Autopsy Rates. Autopsies are encouraged as per VHA policy.
- vii) Autopsy Criteria. VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in JAHVH HPM 11-31, Autopsy Policy. Those cases meeting criteria as Medical Examiner's cases per policy will be referred to the appropriate County Medical Examiner's Office in accordance with state statutes.
- viii) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes. Guidance should be sought from the Office of the Coroner in each case of suspected medico-legal significance.
- ix) Provisional anatomic diagnoses should be available within two (2) working days of the post-mortem exam; complete findings should be available within

90 days. Autopsy findings will be used by the medical staff for performance improvement activities and are a valuable tool in the advancement of medicine and education of physicians.

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

#### **4. PHYSICIANS' ORDERS \***

##### **A. General Requirements**

- i) Orders are entered into the electronic medical record (EMR). Hand-written orders may be used in some situations as designated in Professional Order Policy MS-3 and must include the date, time and signature of the ordering practitioner. All hand-written orders must be legible.
- ii) Verbal orders are strongly discouraged except in emergency situations.
  - (a) Registered Nurses, Pharmacists, and Respiratory Therapists, Physician Assistants, and Nurse Practitioners can accept verbal orders. Verbal orders are usually one time orders but can be repeated depending on the ordered frequency for a maximum of 24 hours. To continue beyond 24 hours, the order must be written by the practitioner on the same or next day and within the 24 hour time period.
  - (b) Verbal orders may be used for urgent patient care situations. Urgent care situations include those in which the registered nurse contacts the physician to initiate orders regarding treatment concerns or for the patient's comfort (e.g. diet, sleeping medication, pain medication).
  - (c) Verbal orders will not be accepted for admission orders, inter-hospital transfer orders, discharge orders, or orders for cytotoxic agents. These situations are considered high risk and require physical assessment by the provider before orders can be given.
  - (d) In the Same Day Surgery Unit and the 23 Hour Observation Unit, verbal orders may be used to expedite outpatient care and treatment and outpatient transfer, or discharge from an outpatient area.
  - (e) A verbal order must be clearly understood by the recipient, then entered into CPRS and read back to the provider for verification of accuracy before implementation.
  - (f) Only practitioners who have knowledge of the patient should issue verbal orders for that patient.
  - (g) All verbal orders must be signed by the ordering practitioner within 24 hours of order entry.
- iii) Telephone orders will be accepted when the provider is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS. They will be accepted by Registered Nurses, Pharmacists, Physician Assistants, Advanced Practice Registered Nurses, Certified

Registered Nurse Anesthetists, etc. as designated by facility policy and when it clearly is in the best interest of patient care and efficiency. Appropriate staff receiving the order telephonically will first write down the verbal order and read back the order to the physician to ensure correctness. Verbal/telephone orders will be entered by the nurse or pharmacist and signed electronically by the physician within 24-hours or the next working day whichever is earlier.

- iv) Orders are to be generated only by medical staff or other individuals within the authority of their clinical privileges/scope of practice.
- v) Medication orders
  - (a) Must contain dosage, frequency, and route.
  - (b) Use of "p.r.n." and "on call" must be qualified.
  - (c) Medication orders are required for patients to take medication brought into the medical center or for the patient to self-administer.
  - (d) A change in patient status, renewal date of physician's medication order, or evaluation by the treatment team will be indications for review or revision of medication orders.
- vi) Pharmacists may change the following data elements in an order entered by a provider in order to fill the order appropriately:
  - (a) Orderable Item
  - (b) Dosage Ordered
  - (c) Medication Route
  - (d) Schedule
  - (e) Special Instructions - if pharmacist states "yes" to include these in the order
  - (f) Start Date
  - (g) Stop Date
- vii) Policy Orders: A policy order is a clinical protocol that has been clearly defined in writing and formally approved by the Clinical Executive Leadership Board for use in a specific clinical area, can be entered into the medical record by authorized staff, and implemented without a co-signature of the order by a physician. Policy orders may include routine lab orders, x-rays, EKG, diets, and other non-invasive tests and procedures. Medications are not included as policy orders except in designated areas e.g. Critical Care Center (drugs to be administered at the onset of an arrest) and Primary Care (flu vaccine). Policy orders will not include orders for CT scans, MRIs, or studies or procedures involving the use of IV contrast agents or intravenous solutions. The individual entering the policy order will designate the name of the provider responsible for follow-up of the order during entry of the order. Results obtained from any policy orders (e.g. abnormal test results) will be transmitted back to the designated provider as a view alert
- viii) Cancellation of Orders
  - (a) The following situations cancel all previous orders:

- (1) Patient transfers to another treating specialty.
  - (2) Patients who have gone to the Operating Room (Exception: Patients who have gone to the operating room for a minor procedure and return to the same treating specialty. Generally, a minor procedure is an operation that is performed under local anesthesia in less than 60 minutes.)
- (b) The phrase: "Resume Previous Orders" is not acceptable. All orders must be re-entered.

## B. Medication Orders

- i) All drugs used in the Facility must be on the National Formulary and additions as approved by the VISN Pharmacy and Therapeutics (P&T) Committee or be Investigational Drugs that have been approved by the Research and Development Committee and the Facility P&T committee. Exceptions to the foregoing requirements may be made in use of "provisional drugs" or "non-formulary drugs" which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN level. Exceptions are based on an individual patient case by case basis.
- ii) All drugs used in the Facility will be stored and dispensed by the Pharmacy.
- iii) Duration of Orders:
  - (a) Schedule II controlled drugs will be written for periods not to exceed fourteen (14) days for in-patients and must be reentered by electronic entry into EMR for each succeeding period of 14 days or less.
  - (b) Schedule III – V controlled drugs may be written for a period not to exceed thirty (30) days.
  - (c) Antibiotics orders must include the duration of the therapy.
  - (d) Orders for all other drugs will be written for a period not to exceed thirty (30) days from the date the first medication was ordered before they expire and must be rewritten.
- iv) Ambulatory Care Medication Orders:
  - (a) All prescriptions must be entered electronically except for Schedule II Controlled Substances.
  - (b) All prescription controlled substances will follow VHA Handbook 1108-1.
  - (c) Ninety (90) days is the maximum duration for applicable outpatient prescriptions.
  - (d) The number of refills authorized on a single prescription may not to exceed one year.
- v) Domiciliary Care Medication Orders:
  - (a) All prescriptions must be entered electronically.



- (b) Controlled substances are limited to a 7 day supply.
  - (c) Thirty (30) days is the maximum duration for Domiciliary Care prescriptions
  - vi) Transfer of Patients: When a patient is transferred from one level of care to another level of care, or there is a change in physician of record, orders must be written for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.
- C. Standardized Order Sets (protocols): An order set is a template of orders used by providers in a specific clinical area. An order set can be individualized for each patient and must be signed by the provider before the orders can be implemented. Standardized order sets are reviewed periodically by Section Chief or Service Line Vice President and modified as needed. All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by medical staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section Chief or Service Line Vice President.
- D. Investigational Drugs: Investigational drugs will be used only when approved by the appropriate Research and Development Committee and the P&T Committee and administered under approved protocol with patient informed consent, under the direct supervision and legitimate order of the authorized Principal Investigator or designated investigator.
- E. Informed Consent:
- i) Informed consent will be consistent with legal requirements and ethical standards, as described in Facility policy Informed Consent.
  - ii) Evidence of receipt of Informed consent, documented in the medical record, is necessary in the medical record before procedures or treatment for which it is required.
  - iii) Surgical, invasive and non-invasive procedures, operative blood transfusions and anesthesia will be initiated only with the prior, informed and voluntary consent of the patient. Informed consent will include a full explanation of the risks, benefits and alternatives of therapy with the patient.
  - iv) The following elements are to be addressed during informed consent and documented in the patient's medical record by the practitioner who obtained the consent:
    - (a) Relevant aspects of the proposed procedure/treatment;
    - (b) Indications for the procedure/treatment;
    - (c) Reasonable foreseeable risks;
    - (d) Potential complications or site efforts;
    - (e) Expected benefits;
    - (f) Reasonable and available alternative therapies; and
    - (g) Anticipated outcome if the procedure/treatment is or is not performed.

Documentation in the medical record should also include a statement that the patient (or surrogate decision maker) had the opportunity to ask questions, identified their decision was made without duress or coercion.

- v) Documentation of informed consent will be considered valid for a period of 60 calendar days. If treatment involves multiple visits or procedures pursuant to the authorized treatment plan obtained, the informed consent will be valid for the entire anticipated period.
- vi) Consent will be obtained electronically using IMED except for administrative or phone consent or when IMED is unavailable. Obtaining consent by telephone shall be done only under circumstances when the physician has deemed it medically necessary that a patient must undergo an invasive procedure. In such a situation, the Business Service Line will follow the appropriate procedures.
- vii) All patients asked to participate in a research project are to be given a full explanation of the expected benefits, potential discomforts and risks, and alternative treatments that might also be advantageous. The patient is to be informed that (s)he may refuse to participate in the research project and that refusal will not compromise their access to services.

F. Submission of Surgical Specimens: All tissues and objects removed at operation shall be sent to the Facility pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.

G. Special Treatment Procedures:

- i) DNR (Do Not Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment
  - (a) A description of the role of the physician, family members and when applicable, other staff in decision.
  - (b) Mechanisms for reaching decisions about withholding of resuscitative services, including mechanisms to resolve conflicts in decision making.
  - (c) Documentation in the medical record.
  - (d) Requirements are described in Facility Policy Memoranda, Medical Staff Bylaws, and these Rules.
- ii) Sedation/Analgesia involves the administration of medications that have a risk for undesirable side effects, either immediately or delayed, and may be utilized only within the guidelines of an established protocol in the center policy related to Sedation/Analgesia and according to approved privileges. Only by those Practitioners with approved and current privileges to do so.

## **5. ROLE OF ATTENDING STAFF \***

A. Supervision of Residents and Non-Physicians

- i) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities. Residents participate in patient care under

the direction of the active medical staff that has clinical privileges at this health care system. Resident supervision includes the examination of the patient, discussion of findings and therapeutic options, a plan for medical care, and documentation of those components of care. Attending physicians assigned to supervise residents must ensure that all diagnostic, therapeutic and surgical procedures performed by residents assigned to the patient are medically indicated and properly executed; must be familiar with each patient the resident is assigned to; must enter periodic notes in the patient's medical record (or at a minimum, authenticate the resident's notes) and verify concurrence of diagnosis and treatment; and must review major significant revisions in treatment plans and/or changes in the patient's level of care and note their concurrence.

- ii) Transfer or discharge of a patient by a resident will be made jointly with the attending physician responsible for the patient's care.
- iii) Residents may enter patient care orders but this does not prohibit the medical staff from entering orders. Orders entered by residents do not require authentication by the attending physician.
- iv) Written descriptions of the roles, responsibilities, and patient care activities of residents (resident PDs) are available on the VAPHS Education website. The descriptions identify a resident's progressive involvement in patient care activities by Post-Graduate Year (PGY Level). Residents will be encouraged to assume increasing levels of responsibility based on the individual's documented knowledge, skill, experience and judgment, consistent with the requirements of the accrediting body.
- v) Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment.
- vi) Mid-Level and certain Associate Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

B. Documentation of Supervision of Resident Physicians

- i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.
- ii) Each patient must have a supervising physician whose name is identifiable in the medical record.
- iii) Evidence of attending supervision must be documented within 24 hours of admission, when there is a significant change in the patient's condition or treatment plan, prior to any invasive procedure and at discharge.
- iv) The attending physician must ensure that all medical records of patients assigned to residents have been appropriately completed, including the history and physical examination, operative reports, and discharge summary

- v) Entries in the medical record made by residents or those non-physicians (e.g., PAs, ARNPs, etc.) that require countersigning by supervisory or attending medical staff members are covered by appropriate Facility policy and include:
  - (a) Medical history and physical examination.
  - (b) Discharge Summary.
  - (c) Operative Reports.
  - (d) Medical orders that require co-signature.
    - (1) DNR.
    - (2) Withdrawing or withholding life sustaining procedures.
    - (3) Certification of brain death.
    - (4) Research protocols.
    - (5) Investigational drug usage, ONLY permitted by named principal investigators or co-investigators previously designated in the study.

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

- vi) Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising Practitioner over and above standard setting-specific documentation requirements (VHA Handbook 1400 page 6).
- C. Designated administrative staff will be authorized to make administrative entries as approved by the Chief of Staff. These administrative entries can be for the purposes of: (1) creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering notes to disposition consultation requests and (5) completing other requirements as requested by the Chief of Staff or his/her designee.
- D. Resident Supervision Requirements in Special Areas
- i) Inpatient Care

- (a) Each patient must have a supervising practitioner whose name is recorded in the medical record.
  - (b) Supervising practitioners will be available for appropriate resident supervision. Each service must provide call schedules that indicate the responsible supervising practitioners and how to contact them.
  - (c) Documentation of supervision will be entered into the medical record as a progress note by the supervising practitioner, or will be reflected within the resident's progress note, or other appropriate entries in the medical record that have been assigned by the supervising physician.
  - (d) The medical record should reflect the degree of involvement of the supervisory practitioner, either by physician's progress note or the resident's description of attending involvement.
  - (e) The attending may choose to countersign or add an addendum to the resident's note detailing the attending's involvement. The note will include the name of the staff practitioner with whom the case was discussed, as well as a summary of that discussion.
  - (f) Patients admitted to an inpatient service must be physically examined and evaluated by the supervisory practitioner and a progress note documenting this evaluation must be entered, within 24 hours of admission including weekends and holidays. The attending's note will include findings and concurrence with the resident's initial diagnosis and treatment plan, as well as any modifications or additions. Supervisory practitioners are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the residents.
  - (g) The discharge or transfer of the patient from an inpatient service must include documentation of physical activity medications, diet, functional status and follow up plans. At a minimum, evidence of this will be documented by the supervising practitioner's countersignature of the discharge summary or discharge note.
- ii) Outpatient Care
- (a) The supervising practitioner must be physically present in the clinic area during clinic hours.
  - (b) Each new patient to the outpatient clinic, for which the supervising practitioner is responsible, should be seen by or discussed with the supervising practitioner. This must be documented via a progress note by the supervising practitioner, or the resident's note, and include the name of the supervising MD and nature of discussion.
  - (c) The supervising practitioner must be identifiable for each residents patient care encounter. Return patients to clinic must be seen by or discussed with the supervising MD at such a frequency as to ensure

the course of treatment is effective and appropriate. Documentation must be entered by the supervising MD or resident and indicate the nature of the discussion with the supervising MD. The attending may choose to countersign and add an addendum to the resident note detailing the attending's involvement.

- (d) The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from clinic is appropriate.
- iii) Consultative Care
  - (a) The supervising practitioner is responsible for consultations and must meet with each patient consulted by a resident and perform a personal evaluation in a timely manner.
  - (b) Supervising practitioner must document consultation by entering a progress note or by concurrence with the resident's consultation note.
  - (c) The attending may choose to countersign and add an addendum to the resident's note detailing the attending's involvement.
- iv) Operating Room Procedures/Same Day Surgical Procedures
  - (a) For all elective or scheduled surgical procedures, a supervising practitioner will evaluate and write a pre-procedure note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedures to be performed. This pre-procedural evaluation and note may be done up to 30 days in advance of the surgical procedure and a reassessment and update documenting any changes in the patient's condition must be completed within 24 hours prior to surgery.
  - (b) Before starting a procedure, the site will be marked and a 'time-out' with the entire team must be done. A time-out is part of the universal protocol for preventing surgery of the wrong site, wrong procedure, or wrong person.
  - (c) During the procedure, the supervising practitioner will provide an appropriate level of supervision based on the level of training of the involved resident and the complexity of the procedure.
  - (d) Operative reports must be dictated after the procedure and an operative progress note must be entered immediately into the medical record.
  - (e) Staff involvement in operating room procedures will be documented in the computerized surgical log (part of the VISTA Surgical Package). The service chief is responsible for periodically reviewing cases done to ensure that the level of supervision is appropriate.
- v) Non OR Procedure
  - (a) Routine bedside and clinic procedures include: skin biopsies, central and peripheral lines, lumbar punctures, centesis and incision and

drainage. Supervision for this activities is dependent in the setting on which they occur.

- (b) Non-routine, non-bedside, diagnostic, or therapeutic procedures (i.e., endoscopy, cardiac catheterization, invasive / radiology chemotherapy, radiation therapy) are procedures that require a high level of expertise in their performance and interpretation. Although gaining experience in doing such procedures is an integral part of the education of the resident, such procedures may be done only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by a supervising practitioner. Supervising practitioners are responsible for authorizing the performance of such procedures and must be physically present in the procedural area.
- vi) Emergency Department
  - (a) The supervising practitioner for the Emergency Department must be physically present in the Emergency Department.
  - (b) Each new patient to the Emergency Department must be seen or discharged with the supervising practitioner.
  - (c) The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the Emergency Department is appropriate.
  - (d) A supervising practitioner is responsible for clinical consultations from each specialty service. When residents are involved in consultation services, the supervising practitioner is responsible for supervision of these residents.
- vii) Emergency Situations: In an emergency, the resident will be permitted to do everything possible to save the life of a patient or save a patient from serious harm but the supervising practitioner must be contacted and apprised of the situation as soon as possible. The resident must document the nature of that discussion in the patient's record.

## **6. MEDICAL RECORDS \***

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

- i) Complete, accurate and timely documentation in a patient's medical record is a medical and legal responsibility of the Medical Staff. All sensitive patient information must be appropriately protected
- ii) Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify author, may include written signatures.
- iii) It is the responsibility of the medical Practitioner to authenticate and, as appropriate, co-sign or authenticate notes by Mid-Level Practitioners.

- iv) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in related Facility policy, and is available in CPRS and VISTA. Those abbreviations are not acceptable for use either handwritten or in the EMR.
- v) The attending physician will be held responsible for the completion of the medical record for each patient. The time requirement for completion of reports of diagnostic and therapeutic procedures is within 24 hours. All on-line documentation is to be signed within 3 workdays after being uploaded into VISTA. Discharge summaries are to be dictated prior to the patient leaving the healthcare system. All medical record documents are to be fully completed within 30 days of discharge.
- vi) Under unusual circumstances the Chief of Staff and Director may authorize signature by means of a rubber stamp. A signed statement is required by the physician to the effect that he/she is the only one in possession of the rubber stamp and is the only one who will use it.
- vii) Medical Students can enter H&P's, notes, consults, and discharge summaries into the patient's medical record, however, all entries must be signed by the supervising resident or attending physician. Progress notes entered by medical students should be entered under the title of "Medical Student Notes". H&P's, consults, and discharge summaries are to be accompanied by an addendum or a separate note from the attending physician to qualify for billing purposes.
- viii) Release of information is required per policy and standard operating procedures for the Facility.
- ix) All medical records are confidential and the property of the Facility and shall not be removed from the premises without permission (ROI from the Patient/consultation with the privacy officer as appropriate). Medical records may be removed from the Facility's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.
- x) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

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

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



- v) Observations, mental status, etc., including results of therapy and treatment plan.
  - vi) Reports of procedures, X-rays, tests, etc. and their results.
  - vii) Progress notes: Dated and timed progress notes will provide a chronological record, pertinent clinical observations and interventions document progress toward achieving goals identified in the care plan and identify plans for discharge.
  - viii) Consultation reports.
  - ix) Diagnostic impressions.
  - x) Conclusions at termination of evaluation/treatment and the patient's condition on discharge and planned follow up.
  - xi) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in Facility Policy Memorandum "Informed Consent."
  - xii) Death note and autopsy, if appropriate.
- C. Inpatient Medical Records: In addition the items listed in section B above, all inpatient records must contain, at a minimum:
- i) A history that includes chief complaint, history of present illnesses, childhood illnesses, adult illnesses, operations, injuries, medications, allergies and adverse reactions, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, chief complaint, and review of systems including vital signs (temperature, pulse, respirations, blood pressure and pain assessment)The Clinical Informatics Team will monitor the quality of medical histories and physical examinations. Any deficiencies will be addressed with the Medical Staff for follow-up.
  - ii) A complete physical examination includes (but not limited to) general appearance, review of body systems, including vital signs (temperature, pulse, respirations, blood pressure and pain assessment), nutritional status, ambulation, self care, mentation, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient assessed personal history. Key examination medical impressions and conclusions will be documented in the note and the planned course of action. The note must be authenticated by provider at the earliest possible time, but always within 24 hours of being written in CPRS.
    - (a) If the H&P was completed prior to the admission or procedure, it must be updated the day of admission. If it is more than 30 days old, a new one must be completed.
    - (b) Inpatient H&P must be completed within 24 hours, 72 hours for long term care; and 7 days for the Domiciliary

- iii) A discharge plan (from any inpatient admission or Domiciliary), including condition on discharge.
- iv) Have a discharge summary (from inpatient or Domiciliary) dictated no later than the day of discharge.
- v) Completed within 30 days of discharge.
- vi) When the patient is readmitted within 30 days for the same or a related problem, an update to the H&P may be used, provided documentation of the original exam is readily available. [An H&P performed within 30 days of admission may be used but an update is required at the time of admission.] Documentation of an update to the original H&P must include an appropriate assessment on admission confirming the necessity for the procedure or case is still present, the patient's condition has not changed since the H&P was originally completed, or any changes are documented.
- vii) Dentists and podiatrists are responsible for the portion of the patients' history and physical examination that relates to their area of practice. A physician is responsible for completion of the remainder of the history and physical examination. H&P's performed by an advanced practice clinical nurse or physician assistant in Medical Pre-Op Evaluation Clinic (MPEC) will be co-signed by the physician in MPEC. The physician in MPEC will approve or disapprove the medical clearance for podiatric or oral surgery.
- viii) A history and physical examination will be performed on each outpatient by the primary care provider during patient enrollment/re-enrollment. The patient will be given an annual physical or, as applicable, or assessment of the condition for which care is authorized. The examining physician must determine the comprehensiveness of the exam based upon the age, sex and previous and current status of the patient.
- ix) A history and physical examination must be in the record prior to any surgical procedure for inpatients and those that will be admitted post-operatively. The medical history shall contain appropriate clinical information relating to the chief or presenting complaint, the history of the acute medical illness determined by the chief complaint, and clinically relevant information regarding the past medical history, social history, family history and review of systems. The physical examination will include the vital signs and elements of an organized examination of the organ system(s) involved in the surgical disease process and general examination of other key organ systems.
- x) In the case of procedures performed on an outpatient basis, including those returning to the 23 Hour Observation Unit post-procedure, also known as Ambulatory Surgery, an abbreviated history and physical will be documented. This must include a relevant review of systems, allergies and medication review. In all instances, an assessment of the case will be recorded documenting the indication(s) for surgery.

- xi) The history will note the clinical problem briefly and the indication for the procedure. Significant medical co-morbidities such as heart disease, diabetes hypertension or malignancy should be mentioned. The physical examination should include basic physical findings of the major organ systems: the lungs, heart, and abdomen and areas of the body being addressed by the procedure. If undergoing general anesthesia or moderate sedation as part of the same day procedure, a cardiopulmonary exam may be completed as a portion of the anesthesia pre-operative assessment.
  - xii) Surgical specialties (including podiatry) may refer operative candidates to the Medical Preoperative Evaluation Clinic (MPEC). MPEC will conduct a history and physical examination and a medical evaluation of co-morbidities for risk stratification. H&P's performed by an advance practice nurse or physician assistant in MPEC will be co-signed by the physician in MPEC. The physician in MPEC will approve or disapprove the medical risk assessment as conducted by an advance practice nurse or physician assistant. MPEC will facilitate surgical decision-making regarding the risk to benefit ratio of surgery and will recommend peri-operative management for medical co-morbidities.
  - xiii) The pre-procedure note may serve as the history and physical for invasive procedure areas as long as all required components are addressed.
- D. Outpatient Medical Records: In addition the items listed in section B above, all outpatient records must contain, at a minimum:
- i) A progress note for each visit including telephone contacts and will be entitled with the name of the clinic.
  - ii) Relevant history of illness or injury and physical findings including vital signs.
  - iii) Patient disposition and instruction for follow-up care.
  - iv) Immunization status, as appropriate.
  - v) Allergies.
  - vi) Referrals and communications to other providers.
  - vii) List of significant past and current diagnoses, conditions, procedures, drug allergies,
  - viii) Medication reconciliation, problem, and any applicable procedure and operations on the Problem List
- E. Emergency Department Medical Records: In addition the items listed in section B and D above, all outpatient records must contain, at a minimum:
- i) The time and means of arrival
  - ii) Care received prior to arrival
  - iii) Disposition at discharge
  - iv) Information regarding an Against Medical Advice (AMA) event, if applicable

v) Discharge instruction sheet is patient is not admitted

F. Surgeries and Other Procedures:

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

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

requirements, s/he will be counseled. If after counseling such deficiencies still remain, appropriate disciplinary action may be initiated.

- vii) Completion of Medical Forms and Medical Statements: VA Healthcare Providers are to honor requests by patients for completion of non-VA medical forms and medical statements and are to follow procedures established by the Release of Information Department before completing non-VA medical forms and medical statements. Non-VA medical forms may include but are limited to:
  - (a) Family Medical Leave Act forms
  - (b) Life Insurance application forms
  - (c) Non-VA Disability Retirement forms
  - (d) State Workman's Compensation forms
  - (e) State Driver's License or Handicap parking forms

## **7. INFECTION CONTROL \***

- A. Isolation is described in Infection Control Policy IC-012 Isolation and Standard Precautions.
- B. Standard Precautions are described in Infection Control Policy IC-012 Isolation and Standard Precautions.
- C. Reportable Cases are described in Infection Control Policy IC-008 Reportable Diseases to the Health Department
- D. It is the responsibility of all Medical Staff to reduce the risk of healthcare-associated infections in the medical center. An Infection Control Manual is available which describes the usage of universal precautions, isolation, and other infection control practices within the healthcare system. The reporting of infectious diseases will be done in accordance with VHA, State and local regulations.
- E. All Medical Staff are expected to comply with hand hygiene guidelines of the medical center.
- F. Immunizations against influenza, hepatitis, etc., are accessible to all Medical Staff through Employee Health.

## **8. CONTINUING EDUCATION \***

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

## **9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM \***

The VAPHS recognizes its responsibility to identify and report professional employees who demonstrate physical, psychiatric or emotional impairment that may pose an actual or potential risk to patient safety. VAPHS recognizes its responsibility to assist impaired professionals and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for the professional employee.

- A. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Line Vice President or Chief of Staff.
- B. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the director of the occupational health program.
- C. In cases of known or suspected impairment due to physical, psychiatric or emotional impairment, the Chief of Staff may request the Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable hospital policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational Health Program or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.
- D. VA and Facility policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for physicians, dentists, and other healthcare professionals.
- E. Confidentiality of the Practitioner seeking referral or referred for assistance will be kept, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.
- F. The hospital will sponsor periodic educational program regarding illness and impairment issues. Licensed independent Practitioners will be issued written information regarding illness issues at the time of initial appointment and re-appointment to the medical staff.

## **10. PEER REVIEW \***

- A. All Medical Staff members shall participate in the facility protected peer review program established by the appropriate VHA policy.

- B. All Medical Staff members will complete ongoing required training associated with the associated VHA policy.
- C. Peer review and case discussion are opportunities for education and improvement of patient care. The peer review process will function to improve the delivery of health care services through a planned process to evaluate the quality of patient care, patient safety, and actual clinical performance. Cases for peer review are identified through various sources (e.g. occurrence screens, incident reports, patient complaints, etc.). An appropriate level of care will be assigned, as a result of peer review process and actions will be taken as appropriate to improve patient care or prevent a recurrence of the problem.

## **11. PAIN MANAGEMENT \***

All patients will be assessed for pain. Appropriate and effective pain management and education about pain will be available to all patients as part of their treatment plan. An opioid analgesic agreement should be reset to minimize risks and adverse outcomes that may be associated with opioid therapy. The agreement should outline the details and expectations for chronic opioid use that have been developed between the provider and patient. Noncompliance with the Opioid Analgesic Agreement can result in an Opioid Block and the patient will be banned from receiving opioid prescriptions from any providers within the VA Pittsburgh Healthcare System.

## **12. DISCLOSURE OF UNANTICIPATED PATIENT TREATMENT OUTCOMES AND ADVERSE EVENTS**

- A. Disclosure refers to the forthright and empathetic discussion of clinically significant facts between providers and/or other VA personnel and patients or their representatives about the occurrence of an adverse event that resulted in patient harm, or could result in harm in the foreseeable future. VA recognizes two types of disclosures:
  - i) Clinical Disclosure is an informal process for informing patients or their representatives of harmful adverse events related to the patient's care. In a clinical disclosure, one/or more members of the clinical team provides factual information to the extent it is known, expresses concern for the patient's welfare, and reassures the patient or representative that steps are being taken to investigate the situation, remedy any injury, and prevent further harm. The clinical disclosure of adverse events needs to be considered a routine part of clinical care, and needs to be made by the attending or senior practitioner, or designee.
  - ii) Institutional Disclosure is a more formal process that is used in cases resulting in serious injury or death, or those involving potential legal liability. In an institutional disclosure the patient or representative and any family members designated by the patient or representative are invited to meet with institutional leaders and others, as appropriate. An apology is made, and information about compensation and procedures available to request compensation is provided, when appropriate.\



- B. Documentation of the disclosure is to be completed in the patient's medical record (an electronic template is available in CPRS).

### **13. TELEMEDICINE \***

A. Telemedicine involves the use of electronic communication technologies to provide or support clinical care at a distance. According to commonly accepted quality standards, the following services have been approved by the medical staff for provision via telemedicine: psychiatry consults, diabetes consults, radiology consults, and follow-up visits for sleep studies. VAPHS physicians who provide care, treatment, and services via telemedicine are to be fully credentialed and privileged to do so at the originating site (site where the patient is located at the time the service is provided through one of the following mechanisms):

- i) the originating site may fully credential and privilege the practitioner;
- ii) the practitioner may be privileged at the originating site using credentialing information from a Joint Commission accredited distant site; or
- iii) the originating site may use the credentialing and privileging distant site if:
  - (a) the distant site is Joint Commission accredited;
  - (b) the practitioner is privileged at the distant site for those services to be provided at the originating site;
  - (c) the originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging a performance improvement.

### **14. DISASTER MANAGEMENT \***

A Disaster Manual is available which describes the role and responsibilities of each service area in a disaster. Key personnel shall rehearse the plan for the care of mass casualties at least twice a year with thorough critiques for effectiveness.

### **15. NATIONAL PROVIDER IDENTIFIER \***

Each provider is required to have a National Provider Identifier (NPI). The following elements in the NPI database must be updated if any changes occur:

- Name;
- Business address and phone number;
- Taxonomy code;
- License number;
- License number state code.

### **16. PERFORMANCE MEASURES \***

All Medical Staff are responsible for complying with all performance measures that are applicable to their work area. Compliance with performance measures will be reflected in the provider's annual performance evaluation.

**17. VAPHS (POLICIES) \***

VAPHS medical center memorandums (policies and procedures) are considered an extension of the rules. They are available to all staff directly on the VAPHS website, through Service Line Vice Presidents and from the office of the Chief of Staff. Policies are available to prospective staff for review upon request.

**18. REQUIREMENT FOR TIME AND ATTENDANCE \***

Providers are responsible for scheduling planned annual leave, sick leave, or authorized absence in advance and are responsible for arranging coverage of their patients during their planned leave. The provider will review all appointments of patients scheduled during the requested period of leave and accommodate patients who must be seen. Whenever possible, patients will be rescheduled within two weeks of the original appointment date, or sooner, if clinically indicated.

**19. REQUIREMENTS FOR CPR CERTIFICATION (BLS AND ACLS) \***

- A. VHA requires all clinically active staff to have CPR education, whether through the American Heart Association Basic Cardiac Life Support (BLS) for Healthcare Providers or through another similar program that includes both CPR and use of public access AED.
- B. Advanced Cardiac Life Support (ACLS) certification is a requirement for Cardiopulmonary Resuscitation Team Leaders, physicians in the Emergency Department, Critical Care, Telemetry, Medical Officers of the Day (MOD) at University Drive, and physicians with moderate sedation and airway management privileges. (Interventional Cardiologists; Interventional Gastroenterologists; Interventional Pulmonologists; Interventional Radiologists; Anesthesiologists).
- C. BLS and ACLS recertification is required every two years.

Adopted by the Medical Staff, VA Pittsburgh Healthcare System, Pittsburgh, PA, this 26th Day of November 2010.

RECOMMENDED

<u>/S/ *</u>	<u>12/1/2010</u>
Ali F. Sonel, M. D., FACC, FACP	Date
Acting Chief of Staff	

APPROVED

<u>/S/ *</u>	<u>12/2/2010</u>
Terry Gerigk Wolf, FACHE	Date
Director	

\* A signed hard copy is on file in the Chief of Staff's office.