

**BYLAWS AND RULES
OF THE MEDICAL STAFF**

VETERANS HEALTH ADMINISTRATION (VHA)

**THE WILLIAM S. MIDDLETON MEMORIAL
VETERANS HOSPITAL & CLINICS**

MADISON, WISCONSIN

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PREAMBLE

Recognizing 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 William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin (hereinafter sometimes referred to as the Hospital, Facility, or Organization) hereby organizes itself for self-governance in conformity with the laws, regulations, and policies governing the Department of Veterans Affairs (VA), 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.

The William S. Middleton Memorial Veterans Hospital comprises an 87-bed acute care facility with patient care programming that includes (but is not limited to) home based primary care, tele-health, intensive mental health community support, and residential substance abuse treatment. The Hospital also is responsible for five community based outpatient clinics (CBOCs), supports a Veterans' Outreach Center in Madison, an Annex Clinic in Madison, and a 26-bed Community Living Center (CLC).

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

DEFINITIONS

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

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 (AD): The AD fulfills the responsibilities of the Director as defined in these Bylaws when serving in the capacity of Acting Director.
3. Associate Director for Patient Care Services (AD-PCS): The AD-PCS (or 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 Council (NEC) and a member of the Medical Executive Council (MEC). The AD-PCS is a member of the Quadrad Leadership team and as such, acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients. S/he actively manages the 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.

4. Associated Health Professional: As used in this document, the term “Associated Health Professional” is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine. These professionals include, but are not limited to: Pharmacists (PharmDs), psychologists, podiatrists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.
5. Automatic Suspension of Privileges: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. 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 MEC.
6. Chief of Staff (COS): The COS is the President of the Medical Staff and Chairperson of the MEC 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 C&P and/or scope of practice system for licensed independent practitioners (LIPS), mid-level practitioners, and associated health practitioners. The COS ensures the ongoing medical education of Medical Staff.
7. Community Based Outpatient Clinic (CBOC): A health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional Medical Staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients. A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VA policies and procedures
8. Director: The Director (also referred to as the 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 COS, the AD, the AD-PCS, and the MEC.
9. Governing Body: The term Governing Body refers to the Director. The Director is responsible for the oversight and delivery of health care by all employees and specifically including the Medical Staff credentialed and privileged by the relevant administrative offices and facility approved processes.
10. Licensed Independent Practitioner (LIP): The term LIP refers to any individual permitted by law and by the William S. Middleton Memorial Veterans Hospital 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, and nurse practitioners. It may also include individuals who can practice independently, who meet this criterion for independent practice.
11. Medical Staff: The body of all LIPs 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.
12. Mid-Level Practitioner: Mid-level practitioners are those health care professionals who are not LIPs and who may practice independently on defined clinical privileges as defined in these Bylaws and by the laws defined by the State of Wisconsin, mid-level practitioners include: Physician assistants (PA), and Certified Registered Nurse Anesthetist (CRNAs).

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 LIP when required. Mid-level practitioners do not have independent admitting privileges to the acute care hospital but may admit to residential programs. They may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations.

13. Organized Medical Staff: The body of LIPs 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.
14. Outpatient Clinic: An outpatient clinic is a health care site where evaluations and treatments of ambulatory patients occur and whose oversight is assigned to a medical facility.
15. Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of practitioner-specific data collected from various sources for the purpose of evaluating current competence.
16. Primary Source Verification: Documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be a letter, documented telephone contact, or secure electronic communication with the original source.
17. Proctoring: Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations. If the observing practitioner is required to do more than just observe, i.e., exercise control or impart knowledge, skill, or attitude to another practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.
18. Professional Standards Board (PSB): The PSB, a subcommittee of the MEC, acts 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.
19. Rules: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the Bylaws. They can be reviewed and revised by the MEC and without adoption by the Medical Staff as a whole. Such changes shall become effective when approved by the Director.
20. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a provider to another 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 health care provider.
21. Telemedicine: The provision of care by a health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.

22. VA Regulations: The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with federal laws. (Example: Code of Federal Regulation (CFR) 38 7402)

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, William S. Middleton Memorial Veterans Hospital.

ARTICLE II. PURPOSE

The purposes of the Medical Staff shall be to:

1. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.
3. Establish and assure adherence to ethical standards of professional practice and conduct.
4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: Care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.
8. Provide a medical perspective, as appropriate, to issues being considered by the Director and Governing Body.
9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.
10. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.
11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.
12. Provide education and training, 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. 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.
14. 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 as well as the means employed to coordinate and supervise their function with the Medical Staff.

15. To provide the best possible inpatient and outpatient care to all persons who are medically and legally entitled to treatment.
16. To provide channels of communication so that matters of a medico-administrative nature may be discussed and problems resolved.
17. To establish hospital policies for patient care and treatment, and to implement professional guidelines.
18. To provide education and training, in affiliation with the University of Wisconsin School of Medicine and Public Health and assure that educational standards are maintained.
19. To initiate and review medical research programs.

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, optometrists, podiatrists, and psychologists who continuously meet the qualifications, standards, and requirements of VHA, this facility, and these Bylaws.
2. Categories of the Medical Staff: The Medical Staff shall be divided into four categories as follows:
 - a. The Active Staff: The Active Staff consists of those employed as full-time and part-time physicians, dentists, optometrists, podiatrists, and psychologists. Physician staff has primary responsibility for patient care and treatment and are appointed to a specific service, shall serve on Medical Staff committees, and shall be required to attend Medical Staff meetings as defined in the rules and regulations of the Medical Staff.
 - b. The Consultant Staff: The Consultant Staff consists of physicians and dentists of recognized competence including, but not restricted to, full-time or part-time members of the faculty of the University of Wisconsin School of Medicine and Public Health. These physicians and dentists visit the hospital on a regular or "on-call" schedule to attend or consult with the Active Staff in the care and treatment of patients. They may also be active in the teaching, training, and research programs. Such individuals will be assigned to a specific service, may serve on designated Medical Staff committees, and may or may not be required to attend Medical Staff meetings. The Bylaws also apply to those consultants who are providing services to patients on a "without compensation" (WOC) basis.
 - c. The Contractual Staff: The Contractual Staff consist of staff that is hired on a contractual basis to provide practitioner services. While such individuals are prohibited by regulation from exercising leadership duties, they may be expected to perform in the following capacities: Serve as professional director for the activities being performed; serve on appropriate medical facility committees and/or boards; monitor and evaluate the quality and appropriateness of patient care services provided and assure that identified problems are resolved. They may or may not be required to attend Medical Staff meetings.
 - d. Other Licensed Independent Practitioners (LIPs): This category contains all other full- and part-time individuals (nurse practitioners, podiatrists, optometrists, and

psychologists) who are permitted by Wisconsin State Law and the hospital to practice independently. Like other practitioners, the privileges delineated for them by the hospital may be less than the array allowed by law.

- e. There shall be two categories of practitioners overseen by the Medical Staff:
 - i) Advanced Practitioners: These are practitioners for whom the Medical Staff may establish broad scopes. This category includes advanced practice nurses who have not yet requested and been granted privileges, specialty nurses, clinical pharmacists, nurse anesthetists, and physician assistants.
 - ii) Other Health Care Professionals: These professionals are required to meet approved standards and to maintain approved levels of proficiency as requirements for the performance of certain services involved in the direct care of patients. The Medical Staff may choose to grant them appropriately narrow scopes of practice.
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, or dentistry from an approved college or university.
 - c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training.
 - d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying.
 - e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.
 - f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VII and VIII 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).

Citizens of the United States or hold an appropriate visa; exceptions may be made when hiring an individual will not conflict with pertinent VHA regulations as interpreted by VISN 12 Human Resources.

2. Clinical Privileges and Scope of Practice: While only LIPs may function with defined clinical privileges, not all LIPs are permitted by this facility and these Bylaws to practice independently. All practitioners listed below are subject to the Bylaws whether they are granted defined clinical privileges or not.
 - a. The following practitioners will be credentialed and privileged to practice independently:
 - i) Physicians
 - ii) Dentists
 - iii) Certified Nurse Practitioners
 - 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) Advanced Practice Nurses
 - ii) Clinical Social Workers
 - iii) Doctors of Pharmacy
 - iv) Clinical Pharmacists
 - v) Psychologists
 - vi) Audiologists
 - vii) Speech Pathologists
 - viii) Podiatrists
 - ix) Optometrists
 - c. The following practitioners will be credentialed and will practice under a scope of practice with appropriate supervision:
 - i) Physician Assistants
 - d. The following practitioners will be credentialed and will practice under a scope of practice with appropriate supervision when not granted clinical privileges as in "b" above.
 - i) Advanced Practice Nurse
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 COS, 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 the 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 it 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 MEC 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 health care 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.

4. Ethics: Full-time Medical Staff members may provide professional care for remuneration outside the VA if it is provided to non-VA patients and outside the staff member's tour of duty. Furthermore, Medical Staff is subject to callback and are responsible for ensuring that any outside employment they accept will not conflict with their VA responsibilities. The Principles of Ethics of the American Medical Association (AMA), the American Dental Association (ADA), the American Nurses Association (ANA), the American Podiatric Medical Association, the American Optometry Association, and VA national and Madison VAH ethics policies shall serve as guidelines for the professional conduct of members of the Medical Staff. Evidence of unethical behavior or behavior-causing discredit to the hospital is cause for separation of any member of the Medical Staff.

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. Composition:

Chief of Staff

2. Qualifications:

Chief of Staff. The COS must be a physician who has had appropriate experience in medical practice, academic affairs, and administration. It is understood that any individual selected as COS 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 hospital. However, the COS may also apply for and be granted specific privileges to provide direct patient care as outlined in Article VII.

3. Selection:

Chief of Staff. The selection of a COS begins with a Search Committee selected by the Director with the consent of the Network Director. The Director should seek advice from the Dean of the University of Wisconsin School of Medicine and Public Health 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 MEC and by the Search Committee. The Committee shall make recommendations to the Director regarding acceptable candidates for the COS along with an explanation of their perceived strengths and weaknesses. From this list, the Hospital Director recommends candidates to the Network Director. The Network Director is responsible for nominating an individual from the recommended candidates and provides information about that individual to the Management Support Office and the VA PSB (VA Central Office). After VA Central Office has completed a technical review of the candidate, the Under Secretary for Health selects the candidate and the Network Director then appoints the COS on behalf of the Governing Body.

Tenure of the COS is determined by the Governing Body, represented by the Network Director. Although the COS 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. Procedures to reduce or revoke the clinical privileges of the COS are identified within VHA Handbook 1100.19, March 19, 2001, Credentialing and Privileging. Other questions or concerns about removal procedures should be directed to the Network Director, and/or the Director of Network Support, VA Central Office, Washington, D.C., and/or the Office of Regional Counsel

4. Duties:

Chief of Staff. The COS acts as the executive officer of the Medical Staff. The COS presides over meetings of the MEC. The COS's office shall facilitate effective communication between the Medical Staff and the Governing Body using written documents and appropriate meetings. The COS will represent the Medical Staff at regularly scheduled hospital administrative meetings and meetings of the Executive Leadership Planning Board (ELPB) and shall assure that the Medical Staff is appropriately represented in any hospital deliberation affecting the discharge of Medical Staff responsibilities. ELPB is one forum for discussing patient satisfaction, patient safety, and sentinel events. The COS will also act as the main representative of the Medical Staff with respect to physician trainee issues. The COS, or designee, is a member of the University of Wisconsin Graduate Medical Education (UW GME) Oversight Committee that monitors the quality of such education. This Committee conducts internal reviews of all specialty training programs. As part of that review, resident supervision, and working conditions are included. In addition, the COS submits an annual report on residency training programs to the VA Office of Academic Affiliations.

Section 4.02 Leadership

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

Section 4.03 Clinical Services

1. Characteristics:

- a. Clinical services are organized to provide clinical care and treatment under leadership of a service chief.
- b. Clinical services encompass all medical and dental programs directly related to patient care and treatment, professional education, and research, and are organized into the following services:
 - i) Anesthesiology, dental, medicine, ambulatory care, social work, rehabilitation, pharmacy, mental health, neurology, nursing, pathology and laboratory medicine, radiology, research, and surgery.
- c. All services, except for pharmacy, social work, rehabilitation, and nursing, are overseen directly by a Medical Staff member. Service leaders who are Medical Staff members must have appropriate board certification or equivalency for the service being overseen. If the service chief is not board certified, the C&P file must contain documentation that the individual has been determined to be equally qualified based on experience, background, and training; this is in accordance with VHA Handbook 1100.19, Credentialing and Privileging. Pharmacy Service and Nursing Service contain practitioners overseen by the Medical Staff.
- d. Ambulatory Care Service is overseen by the Associate Chief of Staff (ACOS) for Ambulatory Care. This ACOS may delegate duties to the Chief of Primary Care. The ACOS for Ambulatory Care oversees the operation of clinics outside the hospital building which are affiliated with the hospital. Research is overseen by the ACOS for Research. Each of the other services is directed by a service chief who is responsible to the COS for the administrative and clinical activities of the service. The chief of each service in turn is responsible to each respective University of Wisconsin School of Medicine and Public Health department head for quality of professional activities as they relate to the teaching program. Because pathology, laboratory medicine, and radiology are operated

as a VISN 12 service line, the service line chief reports both to the Network Director and to the COS. The service line chief has responsibilities similar to other service chiefs with respect to the provision of care and quality of professional activities of the professional staff assigned to this area.

- e. The overall operation of professional services is under the supervision of the COS.
- f. Clinical services hold service-level meetings at least quarterly.

2. Functions:

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

3. Selection and Appointment of Service Chiefs: Medical service chiefs are appointed by the Director based upon the recommendation of the COS. A service chief may be removed by the COS after consultation with the Director for unprofessional, inappropriate, or unethical behavior as delineated in the hospital Code of Conduct.

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

- a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as service chief.
- b. Clinically related activities of the service.

- c. Administratively related activities of the department, unless otherwise provided by the organization.
 - d. Continued surveillance of the professional performance of all individuals in the service who have delineated clinical privileges through FPPE/OPPE.
 - e. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the service.
 - f. Recommending clinical privileges for each member of the service.
 - g. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the service and communicating the recommendations to the relevant organizational authority.
 - h. The integration of the service into the primary functions of the organization.
 - i. The coordination and integration of interdepartmental and intradepartmental services.
 - j. The development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.
 - k. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.
 - l. The determination of the qualifications and competence of service personnel who are not LIPs 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. Conducting at least quarterly clinical service meetings each year to review service issues.
5. The ACOS for Ambulatory Care and service chiefs who are members of the Medical Staff are:
- a. Responsible for recommending to the Medical Staff the criteria for clinical privileges or scopes of practice in their services.
 - b. Responsible for recommending clinical privileges and scopes of practice for practitioners overseen by their services.
 - c. Responsible for continuing surveillance of the professional performance of Medical Staff members who exercise privileges within their services.
 - d. Responsible (in concert with the AD-PCS and Chief of Pharmacy as needed) for continuing surveillance of the professional performance of practitioners with scopes of practice who are collaborating with Medical Staff members in their services.
6. The ACOS for Research is responsible for assuring that research is conducted by members of the Medical Staff in an ethical manner and in accordance with all applicable VHA policies and regulations.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.
 - a. There are a number of standing committees that report to the MEC. Those standing committees are outlined in hospital memorandum, Executive Leadership and Planning Board, No. 00-29.
 - i) The functions and memberships of the Medical Staff standing committees are outlined in numbered hospital memoranda specific to each committee. It is the expectation that the standing committees will review and analyze data and trends, take necessary action, and follow up on those actions. They will present a summary report of trended data and actions completed to MEC, at a minimum, on an annual basis and at times they deem necessary for MEC assistance. Each of these standing committees meets at least two-thirds of scheduled dates.
 - b. Special Committees or Reports: Appropriate special committees shall exist to review and analyze special services or functions provided in the hospital.
 - c. The review by the MEC of such committees and reports constitutes the mechanism by which the MEC establishes and maintains patient care standards.
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 25% of committee members will constitute a quorum.
4. The members of all standing committees, other than the MEC, are appointed by the COS, unless otherwise stated in these Bylaws.
5. Unless otherwise set forth in these Bylaws, the chair of each committee is appointed by the COS.
6. Robert's Rules of Order will govern all committee meetings.

Section 5.02 Executive Committee of the Medical Staff

1. Characteristics: The MEC serves as the Executive Committee of the Medical Staff. The members of the MEC are:
 - a. COS, Chairperson, voting
 - b. Clinical service chiefs, voting
 - c. Practitioners appointed through the Medical Staff process, voting
 - d. Director, or designee, ex-officio, non-voting
 - e. AD-PCS, ex-officio, non-voting
 - f. 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 PA may be called to be present when an action affecting another PA is being considered. Any member of the Medical Staff (with or without vote) is eligible for consideration.
 - g. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.
 - h. The Medical Staff has delegated authority to the MEC. Authority maybe removed by a two thirds majority vote of the active Medical Staff.
2. Functions of the Medical Executive Council (MEC):

- a. Acts on behalf of the Medical Staff within the scope of its responsibilities as defined by the Organized Medical Staff.
- b. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process in support of clinical privileges and/or scope of practice requested; to address the scope and quality of services provided within the facility.
- c. Acts to ensure effective communications between the Medical Staff and the Director.
- d. 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
- e. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, TJC, and relevant external standards.
- f. Oversees process in place for instances of “for-cause” concerning a Medical Staff member’s competency to perform requested privileges.
- g. Oversees process by which membership on the Medical Staff may be terminated consistent with applicable laws and VA regulations.
- h. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.
- i. Monitors Medical Staff ethics and self-governance actions.
- j. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.
- k. Receives and acts on reports and recommendations from Medical Staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body.
- l. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.
- m. Acts upon recommendations from the PSB, which is a subcommittee of the MEC.
- n. Acts upon recommendations from 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 PSB or members may be designated for this purpose by the health care facility Director. Boards may be conducted at other VA health care facilities.
- o. Provides oversight and guidance for fee basis/contractual services.
- p. Annually reviews and makes recommendations for approval of the service-specific privilege lists.
- q. Initiating, developing, and approving Medical Staff Bylaws and rules and regulations. Changes will be communicated to the Medical Staff.
- r. Approving or disapproving amendments to the Medical Staff Bylaws and rules and regulations. Changes will be communicated to the Medical Staff.

3. Meetings:

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

- b. Emergency Meetings: Emergency meetings of the MEC may be called by the COS 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 COS is not available to call an emergency meeting of the MEC, the Director as the Governing Body or Acting COS, acting for the COS, may call an emergency meeting of the Committee.
- c. Meeting Notice: All MEC members shall be provided at least seven 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 COS, or in his absence, such other person as provided by these Bylaws, shall chair meetings of the MEC. 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 MEC 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 MEC, 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 MEC at which action is taken shall be responsible for communicating such action to any person who is directly affected by it.

Section 5.03 Committees of the Medical Staff

1. The following standing committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for Medical Staff membership, (e) reviewing the activities of the Medical Staff and 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. The following committees submit reports to the ELPB on a systematic basis or as requested by the Hospital Director.
 - a. Infection Control Committee:
 - i) Charge: Determine the types of surveillance and infection control activities to ensure an effective hospital-wide program; enforce prevention and control measures when deemed necessary by the Chief of Infectious Disease, Infection Control Practitioner. and/or committee; work with the responsible service chiefs and other hospital staff to correct deficiencies and monitor compliance with established processes [per Committees rev 3, HM 111-12]. Submit committee minutes to the PIQC quarterly and report a summary of its activities to the MEC annually.
 - ii) Composition:
 Chief, Infectious Disease, Chairman
 Nurse Manager, Operating Room
 Nurse Administrative Representative
 Patient Safety Manager
 Nursing Representative

- Supervisory Medical Technologist
- Chief, Supply, Processing, and Distribution
- Organizational Improvement Representative
- Infection Control Practitioner
- Facility Engineer
- Chief, Biomedical Engineering
- Employee Health Nurse
- Dental Representative
- Chief, Environmental & Support Service
- Respiratory Therapy Representative
- Industrial Hygienist
- Safety Manager
- MRSA Prevention Coordinator
- Pharmacy Representative
- iii) Meetings: Meets bimonthly
- b. Invasive Procedure and Blood Usage Review Committee:
 - i) Charge: Establish mechanisms to ensure that only those operations and invasive procedures which are clinically indicated are performed, and that the pathology of any tissue removed is appropriate. Ensure that blood products are available and transfused appropriately.
 - ii) Composition:
 - Chief Pathologist, VISN 12 Pathology and Laboratory Medicine Service
 - Chief, Hematology Section, Medical Service
 - Chief, Anesthesiology Service or designee
 - Chief, Medicine or designee
 - Chief, Surgery Service or designee
 - Associate Director for Patient Care Services or designee
 - Blood Bank Supervisor
 - Organizational Improvement Analyst
 - iii) Meetings: The Committee will hold not less than ten regularly scheduled meetings a year. Blood Usage Review meetings will be held at least quarterly.
- c. Medical Records Committee:
 - i) Charge: Oversee all aspects of the Consolidated Health Record (CHR), both electronic and paper format. Approve all forms and overprints that become a permanent part of the CHR. Systematically review a sample of medical records to ensure compliance with all medical, legal, administrative, and accreditation requirements.
 - ii) Composition:
 - ACOS/Ambulatory Care or designee
 - Chief, Surgical Service or designee
 - Manager, Organizational Improvement
 - Compliance Officer
 - Chief, Health Information Management Section (HIMS)
 - Chief Inpatient Nursing or designee
 - Coding and Discharge Processing Supervisor, HIMS
 - Clinical Application Coordinator, Office of COS
 - iii) Meetings: Quarterly
- d. Mental Health Executive Committee:
 - i) Charge: The William S. Middleton Memorial Veterans Hospital will establish and maintain a Mental Health Executive Council that includes representation from core

mental health professional disciplines and specialty mental health programs. The Mental Health Executive Council is responsible for:

1. Proposing strategies to improve care and consulting with management on methods for improvement and innovation in treatment programs
2. Working to coordinate communication among and between various departments and specialty mental health programs
3. Reviewing the mental health impact of facility-wide policies that include, but are not limited to policies on:
 - a. Patient rights, privileges, and responsibilities
 - b. Restraints and seclusion
 - c. Management of suicidal behavior
 - d. Management of mental health emergencies

ii.) Composition :

Chief, Mental Health Service Line
Manager, Primary Mental Health Division
Manager, Psychosocial Rehab Division
Manager, Addiction Disorder Treatment Program
Manager, Compensated Work Therapy
Manager, MHICM and MHICM-RANGE
Manager, CBOC Mental Health Services
Manager, Homeless Services
Coordinator, Outpatient Clinic
Coordinator, Rockford CBOC Mental Health
Coordinator, Wellness Program
Charge Nurse, Mental Health Outpatient Services
Executive Psychologist
Local Recovery Coordinator
Suicide Prevention Coordinator
Chief, Social Work Service
Representative, Madison Vet Center
Administrative Officer, Mental Health Service Line
Secretary, Mental Health Service Line
Veterans (Madison and various CBOCs)

iii.) Meetings: Meetings are held monthly

e. 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 person-power, facilities, and services; (b) facilitate mechanisms for correction of problems identified; (c) review the performance monitoring activities of each service and the hospital; (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 TJC, and other external reviewing organizations; (f) report to the COS, MEC, and Director pertinent issues concerning the quality control and performance improvement efforts.
Analyze safety data to identify trends and needed actions.
Identify patient safety priorities.
Initiate action teams to address issues and priorities.
Ensure and track the implementation of TJC standards for patient safety.
Identify and facilitate staff patient safety training needs.

Review and assess reports from Root Cause Analysis teams, action teams, risk assessments, patient tracer reports, and other safety reports.

Review VA Patient Safety and Hazard Alerts, TJC Sentinel Event Alerts, and assure local compliance.

Assure that local policies are in compliance with national directives/handbooks.

Review implementation and progress for ongoing national safety initiatives as determined by Institute for Healthcare Improvement (IHI), TJC, or VHA in collaboration with those responsible for implementing these special initiatives.

Alert leadership to patient safety issues that may need resources or other assistance that is beyond the control of the Committee.

Submit committee minutes to the PIQC quarterly and report a summary of its activities to the MEC annually.

ii) Composition:

Patient Safety Manager (provides technical and administrative support)

Associate Director for Patient Care Services/Nurse Executive Manager, Organizational Improvement

Safety Manager

Chief, Pharmacy Service

Chief Medical Resident

Suicide Risk Coordinator

Chief, Mental Health Service Line

Chief, Perioperative and Emergency Nursing Service

Chief, Inpatient Nursing

iii) Meetings: The Committee meets at least ten times per year.

f. Peer Review Committee:

i) Charge: Establish policy, procedures, and responsibilities for the peer review process used to evaluate the practice of practitioners when circumstances suggest the need for such review.

Oversee the peer review process. Reconsider all peer review cases, whether done through a hospital committee or individual, when the level of care has been determined to be Level 2 or 3. Review a sufficient and representative sample of Level 1 peer review cases to ensure the validity and reliability of the findings and to evaluate the peer review process.

ii) Composition:

Chief of Staff, Chair

Chief, Surgery Service or designee

Chief, Mental Health Service Line or designee

Associate Director for Patient Care Services or designee

Chief, Pharmacy Service or designee

Manager, Organizational Improvement or designee, Advisor

Ad hoc members invited at the discretion of the Chair to assist in the peer review process

iii) Meetings: The Committee will meet at least quarterly.

g. Professional Standards Board (PSB)(also serves as Credentials Committee) :

i) Charge: Review applications for appointment to the Medical Staff referred to it by the COS or his designee(s); review the recommendations of the COS and service chiefs; conduct personal interviews of candidates at its discretion; conduct a personal interview with the COS and/or service chief in all instances of disapproval of an application by the COS and/or service chief or both. In the event of the intent of the Committee to recommend disapproval, personal interviews shall be held with the COS and service chief, if appropriate and with the candidate after written notification

- to the candidate of the intended disapproval. Between recertification cycles, review the status and appropriateness of clinical privileges when cases are referred by the COS or service chief. At the request of the COS, review new/proposed changes to delineation of clinical privileges form(s); recommend appropriate action to the PSB or MEC.
- ii) Composition:
 COS
 Chief Medicine Service
 Chief Surgery Service
 Chief Mental Health
 ACOS Ambulatory Care
 - iii) Meetings: Monthly
- h. Research and Development (R&D):
- i) Charge: Evaluate the quality, design, desirability, and feasibility of each new R&D proposal, continuing R&D project, and application for funding, to assure high scientific standards, adherence to the Human Research Protection Program Plan, adequate safety measures, and proper use of animal subjects. Recommend the distribution of R&D funds, space, personnel, equipment, supplies, use of animal facilities, and other common resources, based on the VA Research and Development Information System (RDIS) Budget Allocation. Recommend approval of the receipt and use of non-VA financial support for research and development to be conducted in the facility or by members of the VA staff even if conducted outside the facility and review of grant budgets and other budgetary issues. Advise the Director on the recommendation to the ACOS/R&D of candidates for the position of ACOS/R&D. Fulfill such other functions as may be specified by the Director.
 - ii) Composition:
 Facility ISO (ex-officio/non-voting)
 Chief of Staff (ex-officio/non-voting)
 Distinguished Scientist
 Professor of Medicine, UW
 Staff Neurologist
 Associate Chief of Staff for Research
 Research Compliance Officer (ex-officio/non-voting)
 Research Scientist, UW
 Clinical Neuropsychology Specialist, GRECC
 Research Scientist, GRECC (alternate for Clinical Neuropsychology Specialist)
 Chief, Mental Health Service Line
 Staff Psychiatrist (alternate for Chief, Mental Health Service Line)
 Privacy Officer (ex-officio/non-voting)
 Chief, Electron Microscopy
 Clinical Practice Program Manager, Nursing Service or Magnet Program Manager
 Administrative Officer, Research Service (ex-officio/non-voting)
 Chief, Cardiology Section
 Clinical Pharmacy Coordinator, Chair
 Staff Physician, Pulmonary Section
 Director (ex-officio/non-voting)
 - iii) Meetings: The Committee meets 11-12 times per year.
- i. Therapeutic Agents and Pharmacy Review 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.
Develops and maintains a drug formulary; develops or approves policies and procedures relating to the selection, preparation, distribution, handling, use, safe administration, and monitoring of drugs and diagnostic testing material.
 - ii) Composition: Members of medical, nursing, pharmacy, and administrative staffs
 - iii) Meetings: Monthly
2. Other committees not mentioned here are outlined in Executive Leadership Board memorandum.
 3. Information Flow to MEC: All Medical Staff committees, including but not limited to those listed above, will submit minutes of all meetings to the MEC in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the MEC.

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 MEC, a synopsis of any subcommittee and/or workgroup findings.

Section 5.05 Establishment of Committees

1. The MEC 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 MEC 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 & SERVICE-LEVEL STAFF MEETINGS

1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least quarterly. A record of attendance shall be kept.
2. Special Meetings: Special meetings of the entire Medical Staff may be called at any time by the COS or at the request of the Director or the MEC. A meeting shall also be held upon the request of any three Medical Staff members. 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 COS or Director in writing and stating the reason(s) for the request.

3. Quorum: For purposes of Medical Staff business, 25% of the total membership of the Medical Staff membership entitled to vote constitutes a quorum.
4. Meeting Attendance: Members of the Medical Staff are encouraged to attend all service-level meetings.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. Independent Entity: The William S. Middleton Memorial Veterans Hospital is an independent entity, granting privileges to the Medical Staff through the MEC 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 two 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 LIPs, 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 two years.
3. Deployment/Activation Status:
 - a. When a member of the Medical Staff has been deployed to active duty, upon notification, the privileges will be placed in a "deployment/activation status" and the credentialing file will remain active. Upon return of the practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the practitioner will update the credentialing file to current status.
 - b. After verification of the updated information is documented, the information will be referred to the practitioner's service chief then forwarded to the MEC for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the service chief and Executive Committee to put a focused professional practice evaluation (FPPE) in place to support current competence. The Director has final approval for restoring privileges to active and current status.
 - c. In those instances where the privileges lapsed during the call to active duty, the practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.
 - d. In those instances where the practitioner was not providing clinical care while on active duty, the practitioner in cooperation with the service chief must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care.
4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:

- a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.
- b. Federal law authorizing VA to contract for health care services.

5. Initial Focused Professional Practice Evaluation (FPPE):

- a. The initial 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 requests 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 Human Resources 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(I), 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 (OPPE):

- a. The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the OPPE. This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the Medical Staff leadership. Criteria-based privileges make the on-going monitoring of privileges easier for Medical Staff leadership. Each service chief should consider what hospital, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The maintenance of certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.
 - i) The timeframe for ongoing monitoring is bi-annually.
 - 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 chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a service chief recommending the renewal of privileges, but the service chief must clearly document the basis for the recommendation of renewal of privileges.
 - iv) The PSB and the Executive Committee of the Medical Staff must consider all information available, including the service chief's recommendation and reasons for renewal when criteria have not been met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.
 - v) The Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

Section 7.02 Application Procedures

1. **Completed Application:** Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines. The applicant is bound to be forthcoming, honest, and truthful (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
 - ii) Education
 - iii) Relevant training and/or experience
 - iv) Current professional competence and conduct
 - v) Physical and mental health status
 - vi) English language proficiency
 - vii) Professional liability insurance (contractors only)
 - viii) Basic life support education
 - ix) To qualify for moderate sedation and airway management privileges, the practitioner will have specific, approved clinical privileges and will acknowledge that they have received a copy of "The Sedation and Analgesia by Non-Anesthesia Providers" policy and agree to the guidelines outlined in the policy.
 - b. **U.S. Citizenship:** Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment with proof of current visa status and Immigration and Naturalization Service documentation regarding employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3. (Exceptions to the citizenship requirement may be made when hiring an individual will not conflict with pertinent VHA regulations as interpreted by VISN 12 Human Resources.)

- c. References: The names and addresses of a minimum of four individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer or for individuals completing a residency; one reference must come from the residency training program director. The Director may require additional information.
 - d. Previous Employment: A list of all health care institutions or other organizations where the practitioner is/has been appointed, utilized, or employed (held a professional appointment), including:
 - i) Name of health care institution or practice
 - ii) Term of appointment or employment and reason for departure
 - iii) Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary surrender
 - e. DEA/CDS Registration: A description of:
 - i) Status, either current or inactive
 - ii) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, the practitioner's DEA/CDS registration
 - f. Sanctions or Limitations: Any sanction or penalty by any licensing authority, including current pending challenges, whether a license or registration ever held to practice a health occupation by the practitioner has been suspended, revoked, voluntarily surrendered, or not renewed.
 - g. Liability Claims History: Status (open, pending, closed, dismissed, etc.) of any claims made against the practitioner in the practice of any health occupation including final judgments or settlements, if available.
 - h. Loss of Privileges: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.
 - i. Release of Information: Authorization for release of information, including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.
 - j. Pending Challenges: Pending challenges against the practitioner by any hospital, licensing agency, professional group, or society.
 - k. Whether any complaint or report has been filed with the National Practitioner Data Bank (NPDB), Federation of State Medical Boards (FSMB), state licensing board, or disciplinary body or professional specialty association.
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 four references for initial credentialing, and two 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.
 - d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.
 - e. Evidence and verification of board certification or eligibility, if applicable.
 - f. Verification of education credentials used to qualify for appointment including all postgraduate training.

- g. Evidence of registration with the 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 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 will be obtained.
 - i. Confirmation of health status on file as documented by a physician approved by the Organized Medical Staff.
 - j. Evidence and verification of the status of any alleged or confirmed malpractice.
 - k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, rules, and regulations for the facility to which the application is being made.
 - l. A signed consent for an inspection of all records and documents pertinent to his/her application for Medical Staff membership or clinical privileges and to appear for an interview, if required or requested.
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 health care providers must submit credentialing information into VetPro as required by VHA policy.

Section 7.03 Process and Terms of Appointment

1. **Chief of Service Recommendation:** The chief of the service or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical Staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that service criteria for clinical privileges are met. The service chief or ACOS or their designee will verify the identity of new Medical Staff and confirm that the individual applying for appointment and privileges is the same person whose credentials were verified. Accepted verification includes any form of photo identification from a state or federal agency (driver's license, passport, etc.) or current picture hospital ID card.
2. **CMO Review:** In order to ensure an appropriate review is completed in the credentialing process the applicant's file must be submitted to the VISN Chief Medical Officer (CMO) for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the MEC if the response from the NPDB-HIPDB query indicates that any of the following criteria is met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of \$550,000 or more, or (c) two medical malpractice payments totaling \$1,000,000 or more. The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate

documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the service chief's approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions. (This must be accomplished within 90 days of receipt of application and related documents by the COS, or as soon thereafter as possible.)

3. MEC Recommendation: The PSB and MEC recommend Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met. There must be at least a simple majority of Medical Staff members of the MEC present to conduct business regarding appointments and reappointments.
4. Director Action: Recommended appointments to the Medical Staff should be acted upon by the Director within 30 work days of receipt of a fully complete application, including all required verifications, references, and recommendations from the appropriate service chief and MEC.
5. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or return of the application because of inadequate information. In the case of privilege denial, the applicant is also informed of the reason for denial. The credentialing coordinator notifies the service secretaries of MEC decisions regarding privileging requests. After Governing Body approval, the approved privilege list is sent to the service secretary who in turn sends it to the practitioner.

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, clinical, and/or technical skill to practice within clinical privileges requested.
2. Good Faith Effort to Verify Credentials: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The entry will describe the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. It will also indicate when a secondary source, e.g., copy of diploma, confirmation from someone in practice or training at the same time, is being used in lieu of primary-source verification. The applicant should assist in providing required information for this documentation.
3. Maintenance of Files: A complete and current 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 COS. Any time a file is found to lack required documentation, without an entry as noted above in paragraph two describing the efforts made to obtain the information, effort will be made to obtain the documentation.
4. Focused Professional Practice Evaluation (FPPE): A FPPE will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a "for-cause" event requiring a focused review.

- a. A FPPE, implemented at time of initial appointment, will be based on the practitioner's previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, chart reviews, etc. and should be discussed with the practitioner by the service chief.
- b. A FPPE at the time of request for additional privileges will be for a period of time, a number of procedures, and/or chart review to be set by the service chief.
- c. A FPPE initiated by a "for-cause" event will be set by the service chief. FPPE for cause, where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges i.e., summary suspension
- d. The FPPE monitoring process will clearly define and include the following:
 - i) Criteria for conducting the FPPE
 - ii) Method for monitoring for specifics of requested privilege
 - iii) Statement of the "triggers" for which a "for-cause" FPPE is required
 - iv) Measures necessary to resolve performance issues which will be consistently implemented
- e. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the service's policies and procedures.
- f. If at any time the service chief or designee cannot determine the competence of the practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the service chief:
 - i) Extension of FPPE review period
 - ii) Modification of FPPE criteria
 - iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the practitioner)
 - iv) Termination of existing privileges (appropriate due process will be afforded to the practitioner and will be appropriately terminated and reported)

Section 7.05 Local/VISN-Level Compensation Panels

Local and 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 PSB 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 two years.
2. Reappraisal of privileges is required of each Medical Staff member and any other practitioner who has clinical privileges. Reappraisal is initiated by the practitioner's service chief at the time of a request by the practitioner for new privileges or renewal of current clinical privileges.
 - a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a practitioner's performance.
 - b. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.
 - c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to

the timeliness of the verification and use for the C&P 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 MEC. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 pages 7).

3. A practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the service chief.
4. Associated health and mid-level practitioners who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.
5. Requirements and processes for requesting and granting privileges are the same for all practitioners who seek privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
6. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical service but may be granted clinical privileges in other clinical services. Clinical privileges granted extend to all physical locations of the designated service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all service chiefs must recommend the practice.
7. Exercise of clinical privileges within any service is subject to the rules of that service and to the authority of that service chief.
8. When certain clinical privileges are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.
9. Telemedicine: All practitioners involved in the provision of telemedicine are subject to all existing requirements for C&P, as identified in VHA Handbook 1100.19, Credentialing and Privileging, and related VISN policies.
10. Teleconsultation: All practitioners providing teleconsultation services are subject to existing requirements for C&P, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. Burden of Proof: When additional information is needed, the practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.
2. Requests in Writing: All requests for clinical privileges must be made in writing by the practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.

3. Credentialing Application: The practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
 - a. Complete appointment information as outlined in Section 2 of Article VI.
 - b. Application for clinical privileges as outlined in this article.
 - c. Evidence of professional training and experience in support of privileges requested.
 - d. A statement of the practitioner's physical and mental health status as it relates to practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEC.
 - e. A statement of the current status of all licenses and certifications held.
 - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency, or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits, or settlements (e.g., final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
 - g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.
 - h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
 - i. Evidence of successful completion of an approved BLS education.
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 provider's policy and agree to the guidelines outlined in the policy.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

1. Application: The practitioner applying for renewal of clinical privileges must submit the following information:
 - a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic 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 chief prior to formal submission of privilege requests.
 - b. Supporting documentation of professional training and/or experience not previously submitted.
 - c. A statement of the practitioner's physical and mental health status as it relates to practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEC.
 - 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 C&P 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 chief, 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 chief. 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 MEC followed by the Director's/Governing Body's approval.

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

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.
2. The respective service chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant 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.
 - 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.
3. The MEC, or the committee responsible for the Medical Executive Function, recommends granting clinical privileges to the Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. A subcommittee of the MEC can make the initial review and recommendation but this information must be reviewed and approved by the MEC.
 4. Clinical privileges are acted upon by the Director within 30 calendar days of receipt of the MEC recommendation to appoint. The Director's action must be verified with an original signature.
 5. Originals of approved clinical privileges are placed in the individual practitioner's C&P 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.
 6. Scope of practice and prescriptive authority for mid-level and associate health practitioners is obtained through the respective service chief where the applicant is requesting clinical privileges.

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 COS.
 - a. Temporary privileges are based on verification of the following:
 - i) One, active, current, unrestricted license with no previous or pending actions
 - ii) 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
 - iii) Current comparable clinical privileges at another institution
 - iv) Response from NPDB-HIPDB PDS registration with no match
 - v) Response from FSMB with no reports
 - vi) No current or previously successful challenges to licensure
 - vii) No history of involuntary termination of Medical Staff membership at another organization
 - viii) No voluntary limitation, reduction, denial, or loss of clinical privileges
 - ix) No final judgment adverse to the applicant in a professional liability action
 - b. A completed application must be submitted within three calendar days of temporary privileges being granted and credentialing completed.

2. Expedited Process:
 - a. The practitioner must submit a completed application through VetPro.
 - b. The Facility:
 - 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 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
 - 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 MEC, 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 MEC must be acted upon by the 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 MEC for ratification.
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. Disaster Privileges: Also described in the facility's Emergency Management Plan:
 - a. In the event of the implementation of the organization-wide disaster management plan, disaster privileges may be approved by the COS or in his/her absence the Acting COS 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:
 - (1) A current medical facility photo ID card.
 - (2) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).

- (3) 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 calendar days or length of the disaster, whichever is shorter. Primary source verification of licensure will be obtained within 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 ten 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, LIP, 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.
5. Inactivation of Privileges: The inactivation of privileges occurs when a practitioner is not an actively practicing member of the Medical Staff for an extended period of time such as extended sick leave or sabbatical with or without clinical practice while on sabbatical.
- a. When the practitioner returns to the facility, C&P activities are similar to the initial credentialing process with the exception that non-time limited information, e.g., education and training, does not need to be verified again. Inactivation of privileges may not be used as a substitute for termination of Medical Staff appointment and/or revocation of privileges where such action(s) is warranted.
 - b. At the time of inactivation of privileges, including separation from the Medical Staff, the Director ensures that within seven 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.
6. Deployment and Activation Privilege Status: In those instances where a practitioner is called to active duty, the practitioner's privileges are placed in a deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the practitioner before deployment.
- a. Facility staff request that a practitioner returning from active duty communicate with the facility staff as soon as possible upon returning to the area.
 - b. After the electronic credentials file has been reopened for credentialing, the practitioner must update the licensure information, health status, and professional activities while on active duty.
 - c. The credentials file must be brought to a verified status. If the practitioner performed clinical work while on active duty, an attempt is made to confirm the type of duties, the practitioner's physical and mental ability to perform these duties, and the quality of the work. This information must be documented.
 - d. The verified credentials, the practitioner's request for returning the privileges to an active status, and the service chief's recommendation are presented to the MEC for review and recommendation. The documents reviewed, the determination, and the rationale for the

determination of the MEC is documented and forwarded to the Director for recommendation and approval of restoring the practitioner's privileges to current and active status from deployment and/or activation status.

- e. In those instances when the practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.
- f. In those instances where the privileges lapsed during the call to active duty, the practitioner needs to provide additional references for verification and facility staff need to perform all verifications required for reappointment.
- g. In those instances where the practitioner was not providing clinical care while on active duty, the practitioner in cooperation with the service chief, must consider whether a request for modification of the privileges held prior to the call to active duty should be initiated on a short-term basis.
- h. If the file cannot be brought to a verified status and the practitioner's privileges restored by the Director, the practitioner can be granted a temporary appointment to the Medical Staff not to exceed 60 calendar days during which time the C&P 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

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 COS or the Director. All requests for investigation must be made in writing to the COS supported by reference to specific activities or conduct, which constitute the grounds for the request. The COS promptly notifies the Director in writing of the receipt of all requests. A management review will be recommended for investigation of HR standards. Concerns regarding professional competency will be referred to a PSB. 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.

2. Fact-Finding Process: Whenever the COS 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 14 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 COS may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the PSB.
3. Review by the Professional Standards Board (PSB): The PSB investigates the charges and makes a report of the investigation to the MEC within 14 days after the PSB has been convened to consider the request for corrective action. Pursuant to the investigation, the practitioner being investigated has an opportunity to meet with the PSB to discuss, explain, or refute the charges against him/her. This proceeding does not constitute a hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation by the PSB is an administrative matter and not an adversarial hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations reported to the MEC.
4. Medical Executive Council (MEC) Action: Within 14 days after receipt of a report from the PSB, the MEC acts upon the request. If the action being considered by the MEC 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 MEC 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 MEC.
 - a. The MEC 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 MEC 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 supervision¹, restricting performance of specific procedures, or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.
 - d. Revocation of privileges refers to the permanent loss of clinical privileges.
5. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily

¹ See the definition of Proctoring for an explanation of the difference between proctoring and supervision.

suspend, for cause, or portion of a practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Director.

- a. The COS convenes the PSB to investigate the matter, meet with the practitioner if requested, and make a report thereof to the MEC within 14 days after the effective date of the summary suspension.
 - b. Immediately upon the imposition of a summary suspension, the service chief or the COS 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.
 - b. The COS convenes the PSB to investigate the matter and make a report thereof to the MEC within 14 days after the effective date of the automatic suspension.
 - c. Immediately upon the occurrence of an automatic suspension, the service chief or the COS provides alternate medical coverage for the patients of the suspended practitioner.
 - d. If there are more than three automatic suspensions of privileges in one calendar year, or more than 20 days of automatic suspension in one calendar year, a thorough assessment of the need for the practitioner's services must be performed and documented and appropriate action taken.
7. Union Representation: When the practitioner is a union member, he/she has the right to representation in the interview processes described in paragraphs one through six of this Article IX.
8. Actions Not Constituting Corrective Action: The PSB will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a hearing will not have arisen, in any of the following circumstances:
- a. The appointment of an ad hoc investigation committee
 - b. The conduct of an investigation into any matter
 - c. The making of a request or issuance of a directive to an applicant or a practitioner to appear at an interview or conference before the Credentials Committee, any ad hoc investigating committee, the COS, 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
- 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 COS. 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 COS' written notice of intent. The practitioner must submit a response within ten workdays of the COS' written notice. If requested by the practitioner, the COS may grant an extension for a brief period, normally not to exceed ten 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 workdays after receipt of decision of the Director.

2. Convening a Panel: The Director must appoint a review panel of three unbiased professionals, within five 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
 - iii) Cross-examine witnesses.

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 Director for extraordinary circumstances or cause.
 - a. The panel's report, including findings and recommendations, must be forwarded to the Director, who has authority to accept, reject, accept in part, or modify the review panel's recommendations.
 - b. The Director must issue a written decision within ten 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 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 five 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.
 - e. 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.
 - f. 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.
 - i) 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.
 - ii) The Director will issue a written decision within ten 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.
 - iii) The practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.

- iv) 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.
 - v) 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.
 - vi) 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.
 - vii) 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.
- g. Revocation of Privileges:
- i) Proposed action taken to revoke a practitioner's privileges will be made using VHA procedures.
 - (a) 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.
 - (b) 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.
 - ii) 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 MEC 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.
- h. Reporting to the National Practitioner Data Bank²:
- i) 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.

² Reference VHA Handbook 1100.17.

- Attorney) investigate the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.
- ii) 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.
 - iii) 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.
 - iv) 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.
 - v) 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 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.
- i. 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.
 - j. 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 COS, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021, Employee/Management Relations.

ARTICLE XI. RULES AND REGULATIONS

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 MEC present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were

received and reviewed by the members of the Committee prior to the meeting. Medical Staff rules and regulations must be approved by the Director.

ARTICLE XII. AMENDMENTS

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the COS by any member of the Medical Staff. Recommendations for change come directly from MEC. 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 two-thirds majority endorsement of the active Medical Staff.
2. The Executive Committee may adopt urgent amendments to the rules and regulations that are deemed necessary for legal or regulatory compliance. After adoption, these urgent amendments to the rules and regulations will be communicated back to the Organized Medical Staff for review by email. If there is no conflict, the adoption of the urgent amendment will stand approved. If a conflict arises, the alternative dispute resolution or conflict management process should be followed.
3. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
4. All changes to the Bylaws require action by both the Organized Medical Staff and Director. Neither may unilaterally amend the Bylaws.
5. Changes are effective when approved by the Director.

ARTICLE XIII. ADOPTION

These Bylaws shall be adopted upon recommendation of the Organized Medical Staff via vote that constitutes a quorum. They shall replace any previous Bylaws and shall become effective when approved by the Director.

RECOMMENDED

Chief of Staff

Date

APPROVED

Director

Date

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 Executive Council (MEC) serves as the executive committee of the Medical Staff and acts in their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.
- D. Each of the clinical services shall conduct Medical Staff 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.
- E. Information used in quality improvement as referenced in Article IX, cannot be used when making adverse privileging decisions.

2. PATIENT RIGHTS

- A. Patient's Rights and Responsibilities: This organization supports the rights of each patient and publishes policy and procedures to address rights including each of the following:
 - i) Reasonable response to requests and need for service within capacity, mission, laws, and regulations.
 - ii) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
 - iii) Collaboration with the physician in matters regarding personal health care.
 - iv) 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 (COS) or in his/her absence the Acting COS 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.

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

- 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.
- 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 COS.

3. RESPONSIBILITY FOR CARE

A. Conduct of Care :

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

- a. Medical history including:
 - i. Chief complaint
 - ii. Details of present illness
 - iii. Relevant past, social, and family history
 - iv. Inventory by body system, including pain assessment
 - v. Summary of the patient's psychological needs
 - vi. Report of relevant physical examinations
 - vii. Statement on the conclusions or impressions drawn from the admission history and physical (H&P) examination
 - viii. Statement on the course of action planned for this episode of care and its periodic review
 - ix. Clinical observations, including the result of therapy
- (c.) Medical Admission: 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 by the end of the next calendar day. In the event a resident, intern, or mid-level practitioner prepares an admission workup, all will be retained. 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.
- (d.) Community Living Center (CLC): The attending physician or licensed independent practitioner (LIP) is required to perform the patient's medical history and physical examination within 24 hours prior to or 72 hours after the patient's admission or readmission to the CLC. When the medical H&P examination is performed by someone other than the attending physician or LIP within 30 days of admission, the attending physician or LIP performs the following within 24 hours prior to or 72 hours after the resident's admission or readmission:
 - a. Reviews the patient's medical history
 - b. Re-examines the patient
 - c. Updates any findings or other information as needed and provides a summary of the resident's physical condition and psychosocial status subsequent to the initial medical history and physical examination
 - d. Signs and dates the updated information and findings
 Each CLC patient is reassessed by the practitioner based on the plan of care or changes in condition.
- (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 (resident or attending note), by the provider's signature block, or by the mandated/forced co-signature (H&P, progress note, or discharge summary).
- (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 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.
- ii) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and across Departments and services and between all staff members who have clinical privileges.
- iii) There is to be a comparable level of quality of surgical and anesthesia care throughout the facility.

B. Consultations:

- i) 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.
- 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 (PSBs) on the basis of an individual's training, experience, and competence.
- iii) Consultation Essentials:
 - (a.) Face-to-Face Consultations: 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.
 - (b.) Telehealth, Video Consultations: A satisfactory consultation includes remote assessment of the patient and review of the medical record. A written opinion signed by the consultant must be included in the medical record
 - (c.) E-consultations: A satisfactory consultation includes a chart assessment of the patient's case and a written opinion signed by the consultant must be included in the medical record.
- iv) 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.
- v) Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to

see the consultant, this fact must be documented by the consultant in the medical record.

C. Discharge Planning: Discharge planning is initiated as early as a determination of need is made, most often at the time of admission.

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

D. Discharge:

- i) Patients shall be discharged from the facility only upon the written order of the physician or mid-level practitioner 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 30 days of the discharge of the patient including all signatures.
- ii) To improve post discharge continuity of care, the discharge summary may be reviewed in CPRS after being signed by the resident or midlevel provider.
- iii) Patients from ambulatory surgery/procedure unit can be discharged based upon order of LIP familiar with the patient or when the practitioner is not available, based on relevant Medical Staff approved criteria. The practitioner's name is recorded in the patient's medical record.

E. Autopsy:

- i) Autopsy services are provided by Pathology Service. The availability of these services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the performance improvement program within the facility.
- ii) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-155. 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.
- iii) 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).
- iv) 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.
- v) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes.

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

4. PHYSICIANS' ORDERS

A. General Requirements:

- i) Orders are entered into the electronic medical record (EMR).
- ii) Verbal orders are strongly discouraged except in emergency situations.
- iii) Telephone orders will be accepted when the provider is not in the facility and cannot return in a timely manner and does not have ready access remotely to CPRS. They will be accepted by registered nurses, pharmacists, physician assistants, 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.

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 (R&D) 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 inpatient drugs will be written for periods not to exceed seven days for acute or subacute care or 30 days for chronic pain management. Orders must be reentered by electronic entry into EMR for each succeeding period of time.
 - (b.) Schedule III – V controlled drugs may be written for a period not to exceed 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 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 seven day supply.

- (c.) Thirty 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): Standardized order sets are reviewed periodically by section or service chief and modified as needed. All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by Medical Staff. All concerned personnel shall be notified of revisions to standardized order sets by the section or service chief.
- D. Investigational Drugs: Investigational drugs will be used only when approved by the appropriate R&D Committee and P&T Committee and administered under approved protocol with patient informed consent, under the direct supervision and legitimate order of the authorized principal investigator or designated investigator.
- E. Informed Consent:
 - i) Informed consent will be consistent with legal requirements and ethical standards, as described in facility policy informed consent.
 - ii) Evidence of receipt of Informed consent, documented in the medical record, is necessary in the medical record before procedures or treatment for which it is required.
- F. Submission of Surgical Specimens: All tissues and objects except teeth removed at operation shall be sent to the facility pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis.
- G. Special Treatment Procedures:
 - i) DNR and Withholding/Withdrawal of Life Sustaining Treatment:
 - (a.) Documentation requirements in the medical record
 - (b.) 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. Moderate sedation is used 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.
 - ii) Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment.
 - iii) Mid-level and certain associate health practitioners are supervised by the Medical Staff and are monitored under a scope of practice statement.

B. Documentation of Supervision of Resident Physicians:

- i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in facility policy memoranda, Medical Staff Bylaws, these rules, and VHA Handbook 1400.1, Resident Supervision.
- ii) Entries in the medical record made by residents or those non-physicians (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 H&P 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.)
- iii) Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising practitioner over and above standard setting-specific documentation requirements (VHA Handbook 1400 page 6).

- C. Designated administrative staff will be authorized to make administrative entries as approved by the COS. 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 COS or his/her designee.

6. MEDICAL RECORDS

A. Basic Administrative Requirements:

- i) Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify author, may include written signatures.
- ii) It is the responsibility of the medical practitioner to authenticate and, as appropriate, co-sign or authenticate notes by mid-level practitioners.
- iii) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in related facility policy,

and is available in CPRS and VistA. Those abbreviations are not acceptable for use either handwritten or in the EMR.

- iv) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.
- v) Release of information is required per policy and standard operating procedures for the facility.
- vi) All medical records are confidential and the property of the facility and shall not be removed from the premises without permission (Release of Information from the patient/consultation with the privacy officer as appropriate). Medical records may be removed from the facility's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of Medical Staff.
- vii) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332.

B. All Medical Records must contain:

- i) Patient identification (name, address, DOB, next of kin)
- ii) Medical history including history and details of present illness/injury
- iii) Observations, including results of therapy
- iv) Diagnostic and therapeutic orders
- v) Reports of procedures, tests and their results
- vi) Progress notes
- vii) Consultation reports
- viii) Diagnostic impressions
- ix) Conclusions at termination of evaluation/treatment.
- x) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in Hospital Memorandum, "Informed Consent."

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

- i) A history that includes chief complaint, history of present illnesses, medical illnesses, operations, injuries, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, and review of systems.
- ii) A complete physical examination includes (but not limited to) general appearance and a review of body systems, mutation.
- iii) 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.
- iv) Key examination medical impressions will be documented in the note. The note must be authenticated by provider at the earliest possible time, but always within 24 hours of being written in CPRS.
 - (a.) If the H&P was completed prior to the admission or procedure, it must be updated the day of admission. If it is more than 30 days old, a new one must be completed.
 - (b.) Inpatient H&P must be completed within 24 hours, 72 hours for CLC, and 7 days for the Domiciliary.

- v) A discharge plan (from any inpatient admission CLC or domiciliary), including condition on discharge.
 - vi) Have a discharge summary (from inpatient or domiciliary) dictated no later than the day of discharge.
 - vii) Completed within 30 days of discharge.
- D. Outpatient Medical Records: In addition the items listed in section B above, all outpatient records must contain, at a minimum:
- i) A progress note for each visit
 - ii) Relevant history of illness or injury and physical
 - iii) Patient disposition and instruction for follow-up care
 - iv) Referrals and communications to other providers
 - v) List of significant past and current diagnoses, conditions, procedures, drug allergies
 - vi) Medication reconciliation, problem, and any applicable procedure and operations on the Problem List
- E. Surgeries and Other Procedures:
- i) All aspects of a surgical patient's care, including ambulatory surgery, pre-operative, operative and post-operative care, must be documented. Surgical interventions, diagnostic procedures, or other invasive procedures must be documented to the degree of specificity needed to support any associated coding data and to provide continuity of care.
 - ii) Preoperative Documentation:
 - (a.) In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising or staff practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan, and/or choice of specific procedure to be performed; discussion with the patient and family of risks, benefits, potential complications; and alternatives to planned surgery and signed consent.
 - (b.) Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical or Subjective/Objective/Assessment/Plan (SOAP) note addressing pertinent positive/negative information, indications for the procedure, known risks related to the procedure, and a physical exam pertinent to the procedure. A formal consultation to the service for performing the procedure that includes all required content will serve as an H&P if done within 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.
 - (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 COS 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
 - (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
 - (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 patient evaluation on admission to, and discharge from, the PACU, 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 ICU patients, there needs to be at least one documented post-anesthesia visit after leaving the PACU. 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.

7. INFECTION CONTROL

Isolation, standard precautions, and reportable cases as described in Infection Control Policy.

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

- A. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the COS' office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their service chief or COS.
- B. In cases of known or suspected impairment due to mental illness or substance use, the COS may request an assessment by the Impaired Professional Committee (AdHoc).
- C. In cases of known or suspected impairment due to physical and/or mental illness, the COS 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 health care 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. LIPs 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.

11. DISCLOSURE POLICY – VHA DIRECTIVE 2008-002

This policy outlines the hospital's ethical and legal obligation to disclose to patients adverse events that have been sustained in the course of their care, including cases where the adverse event may not be obvious or severe, or where the harm may only be evident in the future. The directive further specifies the required process steps including communications, documentation, and reporting requirements within VHA.

http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1637;

12. Quality Management Directive – VHA Directive 2008-061

- A. The national and local organizational improvement plans supports the VHA's mission, vision, values, and goals as well as the VISN 12 Strategic Goals, the VHA strategic guidance, resource allocation, and associated VHA policies. This quality management plan is designed to improve the quality of health care structures, processes, and outcomes by systematically:
- i) Defining measures of quality and collecting and analyzing data
 - ii) Identifying improvement actions
 - iii) Identifying and managing sentinel events through a defined and implemented process
 - iv) Utilizing information from data analysis to improve quality and safety
 - v) Identifying and reducing unanticipated adverse events through a defined and implemented process
 - vi) Improving health care in all areas and creating a culture of anticipating and preventing adverse events

[http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1778;](http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1778)

13. PART-TIME PHYSICIAN REQUIREMENTS FOR TIME AND ATTENDANCE

This hospital policy outlines requirements and processes governing part-time physicians' work hours including but not limited to work agreements, the establishment of tours; adjustable and fixed, record keeping, and the annual reconciliation of hours worked.

14. PATIENT SAFETY INITIATIVES

Patient safety initiatives are designed to identify and manage actual and potential risks to patient safety, eliminate or control contributing factors to medical and health care errors, and promote organizational and system-wide learning and sharing of knowledge to improve patient safety. Strategies are aimed at preventing injuries to patients, visitors, and staff.

15. CONFLICT OF INTEREST

VHA's commitment's to ensure managers and staff engages in ethical business and health care practices and to ensure compliance with the laws, regulations, and standards which govern these activities and the highest standards of program integrity.

RECOMMEND:



Chief of Staff

Date 6/23/2011

APPROVE:



Director

Date 6/23/2011

Adopted by the Medical Staff, William S. Middleton Memorial Veterans Hospital, Madison, Wisconsin, this 23rd Day of June 2011.