MEDICAL STAFF BYLAWS AND RULES

OF

VA NORTH TEXAS HEALTH CARE SYSTEM

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MEDICAL STAFF BYLAWS / RULES
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BYLAWS OF THE MEDICAL STAFF OF VA NORTH TEXAS HEALTH CARE SYSTEM

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 within VA North Texas Health Care System (VANTHCS) hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing Veterans Health Administration (VHA) and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the Department of Veterans Affairs (VA), and they do not create any rights or liabilities not otherwise provided for in laws or VA Regulations.

These Bylaws and Rules have been based upon the following principles:

That the best interests of the patient must be protected by the joint efforts of administrative and professional personnel;

That all patients of VANTHCS are entitled to care of the highest possible quality;

That such principles are enhanced by an environment in which teaching is an integral part of the program; and

That the development of new knowledge through constant research of disease, preventive health measures and education, and the process of providing health care is essential to the development and maintenance of a high quality patient care environment.

The mission of the Medical Staff of VA North Texas Health Care System is to:

*Provide high quality and compassionate health care to eligible veterans
*Develop highly trained medical professionals
*Integrate academic and patient care functions
*Provide strong leadership for and a commitment to basic and clinical research
*Provide self-governance of members of the medical staff through developing, adopting, amending, and abiding by the Medical Staff Bylaws, Rules, and Regulations.

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

DEFINITIONS

APPOINTMENT - As used in this document the term refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority for providing patient care services at the facility. Both VA employees and contractors may receive appointment to the Medical Staff.

ASSOCIATE DIRECTOR - The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when serving in the capacity of Acting Facility Director.

AUTOMATIC SUSPENSION OF PRIVILEGES – Suspensions that are automatically (administratively) enacted whenever the defined indication occurs which warrants a suspension of privileges, and does not require discussion, investigation of clinical care concerns, or result from concern of substandard care, professional misconduct, or professional incompetence. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care, conduct/behavior issues not impacting patient care or failure to maintain qualifications for appointment, extended sick leave, or other extended leave. Privileges are automatically suspended until the cause of the suspension has been addressed such as the records are completed or the delinquency rate falls to an acceptable level or provider returns to duty. Reactivation must be endorsed by the Executive Council of the Medical Staff (ECMS) and discussion of reactivation should include consideration of a Focused Professional Practice Evaluation (FPPE) depending upon length of time away from practice and reason for the automatic suspension.

CLINICAL PRIVILEGES (PRIVILEGES) – The authority and permission granted to a Medical Staff member to provide specific diagnostic and therapeutic medical, dental, surgical, podiatric, mental health, chiropractic, optometric, psychological services, clinical social work services and/or other clinical patient care based on evaluation of the individual's credentials and performance.

CHIEF OF STAFF (COS) - The physician appointed by the Director to serve as the clinical staff leader and primary liaison with the University of Texas Southwestern Medical Center, our primary affiliate medical school. The COS is responsible for the professional, developmental, and clinical competency aspects of the medical staff within VANTHCS. The Deputy Chief of Staff may also assume this role as designated by the Chief of Staff.

CONTRACT PRACTITIONERS –Contractor or subcontractor Practitioners are subject to compliance of this facility's Bylaws and VA policies as well as being reported to the National Practitioner Data Bank or respective state

licensing board for substandard care, professional misconduct, or professional incompetence. Removal of a contract practitioner from a contract results in an automatic revocation of privileges. The Contract Provider will be afforded a limited fair hearing to determine only if the revocation of privileges was based upon substandard care, professional misconduct, or professional incompetence and reportable to the National Practitioner Data Bank (if Practitioner is a physician or dentist).

DEAN'S COMMITTEE - The Dean's Committee is a committee established by a formal memorandum of affiliation between VANTHCS and the University of Texas Southwestern Medical Center (UTSWMC) and approved by the Under Secretary for Health. It is composed of the Dean (or designee) and senior faculty members of the medical school, appropriate representatives of the Medical Staff of VANTHCS, and other faculty of the school and staff of the facility (including the Associate Director for Patient Care Services) as are appropriate to consider and advise on development, management and evaluation of all educational and research programs conducted at VANTHCS.

DIRECTOR - The Director ("Chief Executive Officer") is appointed by the Governing Body to act as its agent in the overall management of VANTHCS. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS), and the Executive Council of the Medical Staff.

EMERGENCY - A circumstance or condition in which serious harm could result to a patient. Emergency can also mean that the life of a patient is in serious danger and that any delay in treatment would increase this danger or cause imminent harm.

EX-OFFICIO – A member of a body or committee by virtue of the position held (non-voting).

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) - A defined time-limited process whereby the organization evaluates the privilege-specific competencies of practitioners who do not have documented evidence of competently performing the requested privilege at this organization or when there is a question regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process also extends to physician extenders functioning under an approved Scope of Practice. The FPPE is protected under The Federal Privacy Act of 1974 (5 U.S.C. § 522) and under VHA Regulations 77VA10Q.

GOVERNING BODY - The term "governing body" refers to the Under Secretary for Health, the individual to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and

planning, it refers to the VA North Texas Health Care System Director.

LICENSED INDEPENDENT PRACTITIONER – The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by VANTHCS 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 and dentists. It may also include individuals who can practice independently, who meet this criterion for independent practice. Note: The Full Practice Authority (FPA) which was passed on January 14, 2017 permits VA appointed Advance Practice Registered Nurses to practice as Licensed Independent Practitioners regardless of state licensure held and can practice/ be privileged as such if approved by both the facility's Organized Medical Staff and Governance and documented in Medical Staff Bylaws.

MEDICAL STAFF - The term "medical staff" refers to all physicians, osteopathic physicians, dentists, podiatrists, psychologists, chiropractors, clinical social workers, and optometrists who are fully licensed and privileged to provide patient care services independently in VANTHCS. Membership categories of the Medical Staff of VANTHCS are:

A. **ACTIVE STAFF** - Consists of all full-time, part-time and intermittent physicians, osteopathic physicians, dentists, podiatrists, psychologists, chiropractors, optometrists, nurse practitioners, clinical nurse specialists, and licensed independent clinical social workers who are professionally responsible for the specific patient care and/or education and/or research activities of VANTHCS and who assume all the functions and responsibilities of membership on the Active Staff. Members of the Active Medical Staff will be appointed to a specific service, are eligible to vote in VANTHCS activities and serve on Medical Staff committees.

B. **ASSOCIATE STAFF** - Consists of independent practitioners who are utilized to supplement the practice of members of the Active Staff in their roles in patient care, education, and/or research. This category includes without compensation (WOC), consulting & attending, on-station fee basis, on-station contract, Intergovernmental Personnel Act (IPA), or sharing agreement. Consultants and attendings will be appointed to a specific service and will be permitted to serve on committees.

C. **HOUSE STAFF** - The House Staff will consist of those individuals who are graduates of medical, osteopathic, or dental schools engaged in a formal program of postgraduate training and education within VANTHCS, with or without compensation. The Dean's Committee recommends them for appointment for a limited period of training subject to the regulations of the Department of Veterans Affairs. They are not afforded clinical privileges except as noted below. They will

function only under the supervision of a qualified practitioner who has clinical privileges in the area being supervised. However, they are expected to function in a manner that is consistent with the Bylaws and Rules of the Medical Staff. Unless specifically included as voting members, they will serve as ex-officio members on designated hospital committees.

Chief Residents (Medical Service) who supervise more junior residents and fellows are residents allowed to function outside of their training activity (e.g. hired as an Admitting Physician) and must be granted clinical privileges through the usual credentialing process. Chief Residents are either Board Certified or Board Eligible in Internal Medicine.

D. **AFFILIATE STAFF** - Consists of members of the Health Professions who participate directly in the management of patients under the general supervision or direction of Medical Staff members. Individuals who hold membership on the Affiliate Staff will be appointed to a specific service and will carry out their activities subject to service policies and procedures. Affiliate Staff will include, but is not necessarily limited to Certified Registered Nurse Anesthetists, Clinical Pharmacy Specialists, and Physician Assistants. They will be permitted to serve as ex-officio members on committees of the Medical Staff.

The qualifications, clinical duties and responsibilities of specific categories of Affiliate Staff include:

1. CLINICAL PHARMACY SPECIALISTS (CPS)

a. Qualifications include those as outlined in VA Handbook 5005, Part 11, Appendix G15.

b. Pharmacy Service will normally maintain administrative responsibility for CPS's; however licensed pharmacists may be individually supported by an appropriate clinical service. Medical supervision will be as stated in specified scope of practice documents based on an appropriate evaluation and credentialing process.

c. A clinical scope of practice will be established for each CPS via a credentialing review process that includes physician involvement for those clinical services affected. This will be accomplished before the scope of practice is forwarded to the credentialing board for review. Final approval will be according to procedures and policies applying to the credentialing board. Reference VA 5005, Part II, Chapter 3, section B.

2. NURSE ANESTHETISTS

a. Qualifications - The individual must be a citizen of the United States, a graduate of a school of nursing approved by the appropriate State Accrediting Agency at the time the program was completed by the applicant, and a graduate of a school of anesthesia approved by the American Association of Nurse Anesthetists.

b. Clinical Duties and Responsibilities - Nurse Anesthetists function as members of an anesthesia care team (Nurse Anesthetist and Physician Anesthesiologist). The training, experience, and demonstrated current competence of nurse anesthetists will be taken into full account when a clinical scope of practice is established for each provider. The Scope of Practice of each provider will be established by the chief of the service with the individual provider. In general, nurse anesthetists will:

1) Exercise judgment in the clinical assessment and recommendations for induction of, maintenance of, and emergence from anesthesia care.

2) Within the Scope of Practice, write orders, record reports, and write progress notes in the medical record. A countersignature by a physician member of Medical Staff will be required for all written medication orders. Orders for diagnostic tests should be included in the scope of practice.

3) Nurse anesthetists will carry out their activities subject to Anesthesiology and Pain Management Service policies and procedures, and in conformity with the applicable provisions of the Medical Staff Bylaws and Rules.

3. PHYSICIAN ASSISTANTS (PA)

a. Qualifications - The individual must be a citizen of the United States and have either a Bachelor of Science degree (BS) from an AMA/CAHEA accredited program or a BS degree in health-related science with at least 12 months of training in an AMA/CAHEA accredited program. Additionally, all newly hired PAs must be certified by the National Commission of Certification of Physician Assistants.

b. Clinical Duties and Responsibilities - The training, experience, and demonstrated current competence of the physician assistant will be taken into full account in the Clinical Scope of Practice within which each PA will function. The Physician

Assistant Clinical Scope of Practice will delineate the routine duties, non-routine duties/non-emergency duties, emergency duties, and miscellaneous activities that they may undertake. (Reference VANTHCS Memorandum No. 11C-04, "Physician Assistants Scope of Practice"). Physician Assistants will be individually assigned to an appropriate clinical service and will carry out activities subject to service policies and procedures, and in conformity with the applicable provisions of the Medical Staff Bylaws and Rules.

NURSE EXECUTIVE (Associate Director for Patient Care Services) - The Nurse Executive is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he acts as full assistant to the Director in the efficient management and consultation of clinical and patient care services to eligible patients, the active maintenance of a credentialing, scope of practice, and privileging system for relevant mid-level advanced practice professionals and certain associated health staff and in ensuring the ongoing education of the nursing staff.

ONGOING PROFESSIONAL PRACTICE EVALUATION - (OPPE) - As used in this document is a process by which provider-specific performance data are gathered and evaluated for use in reprivileging as well as for identifying and responding to abnormal clinical practice trends. This process will extend to privileged staff as well as practitioners functioning under an approved Scope of Practice. OPPE is protected under The Federal Privacy Act of 1974 (r U.S.C. 522) and under VHA Regulations 77VA10Q.

ORGANIZED MEDICAL STAFF (MEDICAL STAFF) - The body of Licensed Independent Practitioners who are collectively responsible for adopting and amending medical staff bylaws and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges. This body consists of all active staff members of the medical staff.

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. Peer recommendations and reviews in the context of credentialing, privileging, and adverse actions must remain distinct and different from USC Section 5705 protected peer review recommendations and activities.

PRACTITIONER – The general term for a physician, osteopathic physician, dentist, podiatrist, optometrist, psychologist, clinical social worker, chiropractor, physician assistant, advanced practice nurse, or clinical pharmacy specialist who is fully licensed or otherwise granted authority to practice in

a State, Territory, or Commonwealth of the U. S. or District of Columbia and falls within the credentialing requirements outlined in VHA Handbook 1100.19, Credentialing and Privileging.

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.

PROCTORING - Proctoring is the activity by which a Practitioner is assigned toobserve the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the proctoring 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 considered a reduction of privileges for the Practitioner who is being proctored.

RULES - Refers to the specific rules that govern the Medical Staff of VANTHCS as set forth in this document. 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 ECMS and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.

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

TELEMEDICINE - The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient. Telephone and secure text messages are excluded from this definition.

VA NORTH TEXAS HEALTH CARE SYSTEM (VANTHCS) - Consists of the Dallas VA Medical Center, Sam Rayburn Memorial Veterans Center (Bonham, TX), Fort Worth Outpatient Clinic, Tyler Outpatient Clinic, Community Based Outpatient Clinics, and Outreach Facilities.

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 1: NAME

The name of this organization will be the Medical Staff of VA North Texas Health Care System (VANTHCS).

ARTICLE 2: PURPOSE

A. Ensure that all patients treated in VANTHCS will receive efficient, timely, and appropriate effective care that is subjected to continuous quality improvement practices.

B. Ensure all patients being treated for the same health problem or with the same methods/procedures receive the same level of care. Primary care programs will assure continuity of care and minimize institutional care. C. Establish and ensure adherence to an ethical standard of professional practice and conduct.

D. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.

E. Provide educational activities that relate to care provided, findings of quality of care review activities, and expressed need of caregivers and recipients of care.

F. Ensure a high level of professional performance of practitioners authorized to practice in the facility through continuous quality improvement practices and through appropriate delineation of clinical privileges.

G. Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.

H. Bring Medical Staff expertise to deliberations by VANTHCS Governing Body.

I. Develop and implement performance and safety improvement activities in collaboration with VANTHCS staff and assume a leadership role in improving organizational performance and patient safety.

J. Stimulate research activities and assure that research programs are conducted in accord with the standards established by the Research and Development Committee.

ARTICLE 3: MEDICAL STAFF MEMBERSHIP

3.1 Membership Eligibility

A. Membership on the Medical Staff is a privilege extended only to, and

continued for, professionally competent physicians, osteopaths, dentists, podiatrists, optometrists, chiropractors, licensed clinical social workers, nurse practitioners, clinical nurse specialists, and psychologists who continuously meet the qualifications, standards, and requirements of VHA, VANTHCS, and these Bylaws. Membership may be considered for other licensed practitioners who are permitted by law to provide patient care services independently and who meet the qualifications, standards, and requirements of VHA, VANTHCS, and these Bylaws. Membership is recommended by the ECMS and approved by the Director.

B. Categories of Medical Staff membership include:

1) Active Medical Staff*
2) Associate Medical Staff*
3) House Staff*
4) Affiliate Medical Staff*

*Fully described under definitions

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

D. Granting of clinical privileges is a prerequisite to appointment as a member of the Active Medical Staff.

3.2 Qualifications for Medical Staff Membership and Clinical Privileges/Scope of Practice

3.2.1 To qualify for Medical Staff membership and clinical privileges/scope of practice, individuals who meet the eligibility requirements identified in Section 3.1 must submit evidence as noted 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 the individual's profession in a State, Territory, or Commonwealth of the U. S. or the District of Columbia as required for VA employment.

B. Education applicable to individual Medical Staff members as defined, e.g., hold degree of Doctor of Medicine, Osteopathy, Dentistry (DDS and DMD), Podiatry, Psychology, Chiropractic, Social Work, or Optometry from an approved college or university.

C. Relevant training and/or experience consistent with the individual's

professional assignment and privileges for which s/he is applying. This includes any internship, residency, board certification, or specialty training.

D. Current competence consistent with the individual's assignment forwhich s/he is applying.

E. Health status consistent with physical and mental capability tosatisfactorily perform the duties of the Medical Staff assignment within granted clinical privileges.

F. Complete information consistent with requirements for application and clinical privileges as defined in these Bylaws for a position for which VANTHCS has the patient care need, facilities, support services, and staff.

G. Satisfactory findings relative to previous professional competence and conduct.

H. Proficiency of the English language and the ability to communicate effectively with patients, caregivers, staff, and other professional contacts.

I. Current professional liability insurance as required by Federal andVA regulations for individuals providing service under contract.

J. At the time of initial credentialing and recredentialing, evidence must be provided of current Basic Life Support (BLS) training and/or currentAdvanced Cardiac Life Support (ACLS) certification according to VANTHCS Memorandum 141-09, "Staff Training in Cardiopulmonary Resuscitation and Advanced Cardiac Life Support". Providers who have a handicap (i.e. wheelchair bound) may be excused from this requirement upon the recommendation of the Chief of Staff. Prior to assuming clinical duties, new providers must supply evidence of current certification in BLS and/or ACLSas required by VHA policy. Provider must maintain certification in order to continue provision of clinical duties as required by VHA policy.

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

A. The following Practitioners will be credentialed and privileged topractice independently:

1. Physicians
2. Dentists
3. Clinical Social Workers
4. Psychologists
5. Chiropractors

6. Podiatrists
7. Optometrists

B. The following Practitioners will be credentialed through the Medical Staff process including recredentialing and may be privileged in accordance with the Full Practice Authority, regardless of state licensure held if they hold a VA staff appointment (e.g., WOC, full-time, part-time, intermittent):

1. Nurse Practitioners (NP)
2. Clinical Nurse Specialists (CNS)

C. The following Practitioners will be credentialed through the MedicalStaff process, including recredentialing and will practice under a Scope of Practice with appropriate supervision:

1. Physician Assistants.
2. Clinical Pharmacy Specialists
3. Contract APRNs who are not licensed in a state which recognizes their APRNs as Licensed Independent Practitioners.
4. Certified Registered Nurse Anesthetists (CRNAs) who do not hold a license in a state that recognizes CRNAs as Licensed Independent Practitioners

3.3 General Responsibilities

Medical Staff Members and others with individual clinical privileges are accountable for and have responsibility to:

A. Provide for continuous care and supervision of their assigned patients at a professionally recognized level of quality and efficiency.

B. Observe Patient's Rights pursuant to 38 CFR 17.33 and as otherwise mandated, in all patient care activities.

C. Actively participate in continuing education, peer review, and Medical Staff monitoring and evaluation, organizational quality improvement activities, and internal and external reviews.

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

1) Abide by Federal law and VA rules and regulations regarding financial conflict of interest and outside professional activities for remuneration.

2) Provide care to patients within the scope of privileges or scope of practice and advise the VANTHCS Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership or to carry out clinical privileges that are held.

3) Advise VANTHCS Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence, or professional conduct as soon as able, but no longer than 15 calendar days of notification of such occurrences and their outcome.

4) Advise the Director, through the Chief of Staff of any and all changes and/or modifications made to any currently active state medical license as soon as able, but no later than 15 calendar days of noted change and/or modification. Note: A change or modification refers to any alteration to the information on file by the state medical board, to include but not limited to, licensure status change (i.e. restriction/probation), criminal charges (i.e., misdemeanors, felonies), convictions, imprisonments, and administrative or judicial professional malpractice proceedings.

5) Contribute to, and abide by, high standards of ethics in professional practice and conduct.

6) Work cooperatively with others in the provision of care, treatment and services.

E. Abide by the Medical Staff Bylaws and Rules and all other lawful standards and policies of VANTHCS and VHA.

F. Abide by the decisions of all duly-appointed Medical Staff committees and cooperate in safe patient care, treatment and services and Medical Staff activities, including performance improvement, utilization review, peer review, and Clinical Service meetings.

G. Meet all educational requirements such as training in computer security, information security, and other VHA mandatory training.

H. Assist in any Medical Staff-approved teaching activities for medical students, interns, residents, fellows, nurses, Medical Staff members, and others as required by the Clinical Service of which they are a member.

I. Participate in emergency or other Clinical Service coverage as specified individually in the requirements of the Clinical Service of which they are a member and to respond to consultation requirements as set forth by VHA, the ECMS, or Chief of Staff.

J. Prepare and complete, in accordance with VHA, The Joint Commission (TJC) and other regulatory requirements, the required clinical record of all patients whose care is provided at VANTHCS. Reference, Bylaws, Rules and Regulations, Part VI, Section E, Medical Records.

3.4 Code of Conduct

A. Acceptable Behavior: The VA expects that members of the medical staff will serve diligently, loyally, and cooperatively. They must avoid misconduct and other activities that conflict with their duties; exercise courtesy and dignity; and otherwise conduct themselves, both on and off duty, in a manner that reflects positively upon themselves and VA. Acceptable behavior includes the following (1) being on duty as scheduled. (2) being impartial in carrying out official duties and avoiding any action that might result in, or look as though, a medical staff member is giving preferential treatment to any person, group or organization, (3) not discriminating on the basis of race, age, color, sex, religion, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by VA, (4) not making a governmental decision outside of official channels, (5) not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government, and (6) with certain exceptions in accordance with 5 C.F.R. 2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

B. Behavior or Behaviors that Undermine a Culture of Safety: VA recognizes that the manner in which its practitioners interact with others can significantly impact patient care. VA strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact.

   Behavior that undermines a culture of safety is a style of interaction with physicians, healthcare system 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, behavior that undermines a culture of safety may reach a threshold such that

it constitutes grounds for further inquiry by the ECMS into the potential underlying causes of such behavior. Behavior by a provider that undermines a culture of safety could be grounds for disciplinary action.

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

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

C. 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.

3.5 Conflict Resolution and Management

A. For VANTHCS to be effective and efficient in achieving its goals, the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict management is the process of planning to avoid conflict when possible and managing to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program,* addresses the conflict resolution and management process available in VA, as well as resources to engage in mediation as well as non-binding, or binding arbitration. The process is also outlined in VANTHCS Memorandum 00-EEO-07, "Alternative Dispute Resolution".

B. It is expected that VANTHCS medical center leadership will make use of these and other resources in communicating expectations to clinicians and other staff that conflictive, disruptive, inappropriate, intimidating, and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff who experience or witness such behavior are encouraged to advise an appropriate supervisor or other individual in their chain of supervision.

C. Conflict between the ECMS and the Organized Medical Staff on issues including, but not limited to, proposals to adopt a rule or regulation or policy or amendment thereto, shall be referred to the Chief of Staff. The Chief of

Staff will meet with the medical staff member(s), if feasible, to review and address the concerns and reasoning for ECMS's recommendation. If the concerns cannot be resolved, the member(s) will be allowed to present their concerns to ECMS for further discussion and reconsideration. The ECMS members will then conduct a second vote for final recommendation to the Director. The Director will consider all discussion, concerns and the final recommendation before making a final decision on the issue.

ARTICLE 4: ORGANIZATION OF THE MEDICAL STAFF

4.1 Officers

The VA has no requirements for "Officers" of the Medical Staff and does not elect Medical Staff Officers. The Medical Staff Bylaws are approved by the organized medical staff, which constitutes the agreement of the leadership organization.

4.2 Leadership

A. The Chief of Staff functions as the President of the Medical Staff and is the senior administrative physician in charge of professional services. The Chief of Staff plans, directs and coordinates activities of the clinical professionals and has direct responsibility for organization and administration of the Medical Staff and for proper functioning of the clinical organization. The Chief of Staff is directly responsible to the VANTHCS Director for the quality of professional care provided in the facility.

1) Selection: The Network Director approves recommendations to the position of Chief of Staff. The selecting organization is responsible to complete and submit information on the selectee to the Leadership Management and Succession Sub-Committee (LMSS). The LMSS support staff (Executive Recruitment Team) in the Workforce Management and Consulting Office will submit templates to the Leadership Management and Succession Sub-Committee and Workforce Committee for information only.

2) Removal: All disciplinary and/or adverse actions involving a Chief of Staff position must be referred to the Office of the Accountability Review (OAR). The OAR Employee Relations division will assign an Employee Relations Specialist to work directly with the proposing and deciding officials.

B. The Medical Staff, through its committees, boards, functional teams, services and Service Chiefs, provides counsel and assistance to the Chief of Staff and VANTHCS Director regarding all facets of the patient care services and programs including continuous quality and performance improvement, goals and plans, mission and services offered.

4.3 Clinical Services

4.3.1 Characteristics

A. Organized to provide clinical care and treatment under leadership of the service chief.

B. Hold service-level meetings and document them via minutes at least quarterly.

C. The following services shall be organized as a component of the medical staff and shall have a service chief or Associate Chief of Staff responsible to the Chief of Staff for the functioning of the service and for the overall supervision of the clinical work within the service. The clinical staff of the VANTHCS shall be organized into the following services.

Ambulatory Care
Anesthesiology & Pain Management Service
Bonham Domiciliary
Central Dental Laboratory
Dental Service
Education
Geriatrics and Extended Care Service
Medical Service
Mental Health
Nuclear Medicine Service
Radiology Service
Radiation Oncology Service
Research & Development
Pathology and Laboratory Medicine Service
Physical Medicine and Rehabilitation Service
Spinal Cord Injury Service
Social Work Service
Surgical Service

4.3.2 Functions

A. Provide for quality and safety of the care and treatment within the service. This includes monitoring, evaluating, and improving the quality of care; patient satisfaction activities; risk management activities; patient safety; and utilization management.

B. Define important aspects of care including type and scope of services, identify indicators used to monitor quality of care, and evaluate actions taken.

C. Maintain records of meetings that include issues discussed,

conclusions, recommendations, actions taken, and evaluation of actions taken.

D. Develop criteria for recommending clinical privileges for its members.

E. Define and develop clinical privilege statements that include procedure and disease classifications.

F. Develop policies and procedures to assure effective management, ethics, safety, communication, and quality within the service.

4.3.3 Selection and Appointment of Medical Staff Service Chiefs

Clinical Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff and any search committee that may have been developed for a given Service. Qualifications will include certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

4.3.4 Duties and Responsibilities of Medical Staff Service Chiefs or Associate Chiefs of Staff

Each clinical service chief will be responsible to the Chief of Staff to provide effective leadership for the activities falling within his/her responsibility. Each clinical service chief is responsible and accountable for:

A. All clinically related activities of the service, including type and scope of services.

B. All administrative related activities of the service, unless otherwise provided for by the VANTHCS Director. This includes budgetary and fiscal responsibilities consistent with the policies and standards of the health care system.

C. Integration of the service into the primary functions of the organization.

D. Coordination and integration of interdepartmental and intradepartmental services.

E. Development and implementation of policies and procedures that guide and support the provision of services.

F. Recommendations for a sufficient number of qualified and competent persons to provide care/service.

G. Continuing surveillance of the professional performance of all

individuals who have delineated clinical privileges in the service.

H. Recommending clinical privileges for each member of the service and recommending to the Organized Medical Staff the criteria for clinical privileges that are relevant to the care provided in the service.

I. Determination of the qualifications and competence of service personnel who are not licensed independent practitioners and who provide patient care services.

J. Continuous assessment and improvement of the quality and safety of care, treatments, and services provided.

K. Maintenance of appropriate quality control and quality improvement programs.

L. Recommendations for space and other resources needed by the service.

M. Recommendations for off-site sources for needed patient care services not provided by VANTHCS.

N. Monitoring of Part-time Physician time and attendance.

O. Assuring service level compliance with national and local performance measures.

P. Assistance in obtaining and maintaining accreditation by TJC and all other applicable accrediting entities.

Q. Taking reasonable measures to promote a high ethical standard of conduct and clinical competence and initiate corrective actions when necessary.

R. Assuming responsibility for and assisting in the preparation of such annual reports, including budgetary planning, and other resources pertaining to the service as required by the ECMS, the Chief of Staff and/or the Director.

S. Maintaining continuing review of the professional service and performance of all practitioners in the service and preparing the required biennial review of each:

1. Assuring that his/her service participates in performance improvement activities and process measurements such as assessment and treatment of patients; medication use; use of blood and blood components; use of operative and other procedures;

efficiency of clinical practice patterns; and significant departure from established patterns of clinical practice.

2. Participating in all phases of administration of that service including internal/external review activities and quality management activities; Office of Inspector General (OIG) and TJC visit preparation and reviews; and the creation and attainment of program goals and relevant health care system goals.

3. Participating in the Peer Review process, as defined by policy; communicating provider progress during the review period as needed for ECMS consideration of medical staff appointment.

T. Assuring that all service personnel are appropriately oriented and that they receive appropriate continuing education.

U. Assuming responsibility for enforcement of the health care system's policies, rules and regulations and of the Medical Staff Bylaws, Rules and Regulations within the service.

V. Assuming responsibility for implementation within the service of actions taken by the ECMS, as appropriate.

W. Supervising the research, education and training programs within the service in cooperation with the person of the appropriate academic departments and the consulting and attending staffs where applicable.

Individuals at the Sam Rayburn Memorial Veterans Center, Fort Worth Outpatient Clinic, and Tyler VA Primary Care Clinic may be responsible for a portion of the above at the service level. This will depend on the level of integration of the specific service as decided by the Chief of Staff.

ARTICLE 5: EXECUTIVE COUNCIL OF THE MEDICAL STAFF (ECMS)

5.1 Composition

The ECMS consists of the following (or their designee):

Chairperson, voting:

Chief of Staff or designee (e.g. Acting Chief of Staff or Deputy Chief of Staff)

Members, voting:

Deputy Chief of Staff
ACOS for Ambulatory Care
ACOS for Education
ACOS for Geriatrics and Extended Care

ACOS for Mental Health
ACOS for Research and Development
Chief, Anesthesiology & Pain Management Service
Chief, Central Dental Lab
Chief, Dental Service
Chief, Medical Service
Chief, Nuclear Medicine Service
Chief, Pathology & Laboratory Medicine Service
Chief, Physical Medicine & Rehabilitation Service
Chief, Radiation Oncology Service
Chief, Radiology Service
Chief, Spinal Cord Injury Service
Chief, Surgical Service

Ex-officio, non-voting:
Director, VA North Texas Health Care System
Associate Director, VA North Texas Health Care System
Assistant Director, VA North Texas Health Care System
Assistant Director for Outpatient Services, VA North Texas Health Care System
Staff Assistant to the Chief of Staff for Operations
Staff Assistant to the Chief of Staff for Quality and Performance
Associate Director for Patient Care Services
Chief, Social Work Service
Chief, Bonham Domiciliary
Committee and Workgroup Chairs reporting directly to ECMS

Technical Advisors, non-voting:
Chief, Quality, Safety and Value Service
Chief, Human Resources Management Service
Chief, Pharmacy Service
Office of Regional Counsel
Other Affiliate Medical Staff may be called upon to serve as resources or attend committee meetings at the request of the Chairperson

A. All Medical Staff members holding service chief or associate chief of staff appointments are eligible for membership on the council. However, the council will call upon the expertise of the entire Medical Staff in its role of facilitating peer review.

B. Membership of the ECMS consists primarily of a majority of physicians, but may include other practitioners as determined by the medical staff. Medical staff members are added or removed from the ECMS through a 2/3 vote of the ECMS members.

C. A quorum for the ECMS is defined as 50% of all voting members, plus one voting member. Once a quorum for a meeting is present, a vote on a motion

requires a > 50% vote of voting members in attendance for approval. A vote to abstain is not considered a vote and should not be used unless there is a conflict of interest or perceived conflict of interest.

5.2 Functions and Responsibilities

A. Act for the Medical Staff between Medical Staff meetings. This authority is delegated and defined by a 2/3 vote of the Medical Staff and the authority may be removed through a 2/3 vote of the Medical Staff.

B. Maintain 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. Act to ensure effective communication between the Medical Staff and the VANTHCS Director;

D. Make recommendations directly to the Governing Body (VANTHCS Director) regarding the:

1. Structure, organization, and function of the Medical Staff.
2. Mechanisms used to review credentials and delineate clinical privileges.
3. Recommendations of individuals for Medical Staff membership and termination of membership.
4. Recommendation for delineating clinical privileges for each eligible individual.

E. Coordinate the ongoing review, evaluation, and organization of quality improvement activities of the Medical Staff and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.

F. Oversee the process for addressing instances in which there is "for-cause" concern (substandard care, professional incompetence or professional misconduct) related to a medical staff member's competency to perform the requested or held privileges.

G. Oversee the process by which membership on the Medical Staff may be terminated consistent with applicable laws and VA regulations.

H. Oversee the process for fair-hearing procedures that are consistent with approved VA mechanisms.

I. Monitor Medical Staff ethics and self-governance actions.

J. Receive and act on reports from medical staff committees, services, etc., as

appropriate, and makes needed recommendations to the Governing Body.

K. Consider and approve privilege competency and clinical pertinence review criteria on an ongoing basis.

L. Determine professional medical policies of VANTHCS, subject to VHA and Federal regulations, recommended by reporting committees.

M. Annually review and make recommendations for approval of the Service-specific privilege lists.

N. Provide oversight and guidance for fee basis/contractual services.

5.3 Reporting

With the exception of credentialing and privileging matters, the ECMS will report to the Executive Quality, Safety, and Value Board (EQSV). All credentialing and privileging matters will be reported directly to the Director for final action.

5.4 Committees and Workgroups that Report to ECMS

The committees and workgroups of the ECMS for VANTHCS are listed below. The policies covered by each of the committees are listed on the VANTHCS Intranet homepage for viewing or printing. Reports are given at various intervals to the members at ECMS meetings.

5.4.1 List of Committees and Workgroups

Acute Ischemic Stroke
Cancer
Critical Care
Geriatrics/Extended Care Operations
Health Information Advisory
Home Respiratory Care Team
Infection Prevention and Control
Mental Health
Out of OR Procedures
Pain Management
Patient-Aligned Care Teams (PACT)
Peer Review
Pharmacy and Therapeutics (P&T)
Prevention of Amputation in Veterans Everywhere (PAVE)
Surgical
Transfusion Utilization
Women Veterans Health Program

5.4.2 General Responsibilities of Committee Members

1. Committees and workgroups appointed under this Article will report and make recommendations to ECMS as outlined in individual committee charters, available on VANTHCS intranet. Timely and regular reporting of minutes and Executive Summaries to ECMS is required.
2. Committees and workgroups will meet at regular intervals and implement policies and processes that support VHA and VANTHCS.
3. Members will attend and participate in work of the committee or workgroup.

5.5 Committee Records

A. All ECMS committees and workgroups prepare and maintain reports of issues discussed, conclusions, recommendations, actions taken, and evaluation of actions taken, using the standardized station format.

B. ECMS provides for appropriate and timely feedback to the Services regarding all information regarding the Services and their staff.

C. Written minutes shall be made and kept on all meetings of the ECMS, and shall be open to inspection by practitioners who hold membership on the Medical Staff.

D. ECMS and workgroup minutes are maintained with Quality, Safety and Value Service with the exception of minutes for credentialing and privileging matters. ECMS credentialing and privileging minutes are maintained in the Medical Staff Office under the Chief of Staff. Individual ECMS reports from its various committees and workgroups are maintained in Quality, Safety and Value Service, and the Executive Summaries are a regular part of the ECMS minutes.

5.6 Committee Attendance

Medical Staff members, or their designated alternates, will attend a minimum of 50% of the meetings of committees of which they are members, or as required by specific committee directives or policy, unless specifically excused by the committee chairperson for appropriate reasons, e.g., illness, leave, clinical requirements, etc. Committee minutes will specify members absent, excused, designated alternates, and members present.

ARTICLE 6: MEDICAL STAFF MEETINGS

6.1 General Provisions

A. The Medical Staff meets at least annually.

B. Regular meetings are convened at the call of the Chief of Staff. Special

meetings may also be convened at the call of the Chief of Staff as needed.

C. Members of the active Medical Staff are voting members.

D. Minutes of all meetings will reflect issues discussed, conclusions, recommendations, actions taken, and evaluation of actions taken.

6.2 Rules of the Medical Staff

The Medical Staff will adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws and guidelines of the Governing Body, subject to approval by the VANTHCS Director. Such rules will become a part of these Bylaws. Proposed amendments may be made following the same process outlined in Article 12 of the Bylaws.

6.3 Quorum and Voting

A quorum for purposes of Medical Staff meetings, committee meetings, and service staff meetings is defined as 50% or more of the voting membership of VANTHCS Medical Staff, the committee, or the service, respectively.

ARTICLE 7: CREDENTIALING APPOINTMENT AND REAPPOINTMENT

7.1 General Provisions

A. Independent Entity: VANTHCS is an independent entity, granting privileges to the medical staff through the ECMS and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical staff appointments and reappointments may not exceed 2 years. Medical staff practitioners must practice under their privileges or scope of practice.

B. Credentials Review: All practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment, at the time of reappraisal for granting of clinical privileges or scope of practice, or after a break in service. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a maximum period not to exceed 2 years.

C. All members of the Medical Staff who hold clinical privileges or a scope of practice will be subjected to an initial Focused Professional Practice Evaluation at the time of initial appointment, obtaining a new privilege, or after a significant break in service or utilization. At the time of reappraisal for reprivileging, the service chief will utilize Ongoing Professional Practice Evaluations along with all other data in his/her decision whether or not to recommend retention.

D. Appointments to the Medical Staff occur in conjunction with VA employment or utilization under a VA contract or sharing agreement. The authority for these actions is based upon:

1. Provisions of 38 U.S.C. in accordance with Department of Veterans Affairs Manual MP-5, Part II, Chapter 2 and its supplements and to Title 5 regulations 316.402(a), 315.501, 315.502 and applicable Agreement(s) of Affiliation in force at the time of appointment.

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

E. Probationary Period - Initial and certain other appointments made under 38 U.S.C.7401(1), and 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies and procedures. 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 similar processes to the evaluation of individuals employed under provisions of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements. For further details, see VA Handbook 5021/5, "Employee/Management Relations".

F. Deployment/Activation Status:

1. When a member of the medical staff has been deployed to active duty, upon notification, the privileges will be considered in a "Deployment/Activation Status" and the credentialing file will remain active. The Deployment/ Activation status must be documented for informational purposes in the ECMS minutes. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of l994 (USERRA), the Practitioner will update the credentialing file to current status.

2. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the ECMS for recommendation to restore privileges to active, current status, based on evidence of current competence. The Director has final approval for restoring privileges to active and current status. The service chief and Medical Executive Committee should consider putting a FPPE in place to confirm clinical current competence depending upon the length of time away from the facility or other circumstances.

3. In those instances where the privileges/scope of practice lapsed during the call to active duty, the Practitioner must request privileges/scope of

practice and submit information for recredentialing prior to appointment.

4. In those instances where the Practitioner did not provide 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.

G. 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:

1. 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.

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

H. Termination of Medical Staff appointment will be accomplished in conjunction with, and will follow, procedures for terminating appointments of practitioners set forth in VA Handbook and Directive 5021, VHA Handbook 1100.17, VHA Handbook 1100.18 and VHA Handbook 1100.19.

7.2 Application Procedures

7.2.1 Documentation

A. Applicants for appointment to the Medical Staff must submit a complete application. To be complete, applications for appointment must be submitted by the applicant in electronic format in VHA's secure on-line Federal Credentialing Program application in VHA's Electronic Credentialing System and on forms approved by VA and/or the facility. This must include authorization for release of information pertinent to the applicant, as well as information regarding:

1) Items specified for Qualification for Medical Staff Membership:

a. Active, current, full and unrestricted license;
b. Education as required for the position;
c. Relevant training and/or experience;
d. Current professional competence and conduct;
e. Physical and mental health status as confirmed 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 or scope of practice being sought;

f. English language proficiency;

2) 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 or status as a Permanent Resident and documentation from the United States Central Immigration Service (USCIS) of employment authorization, verified by Human Resources Management Service and pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.

3) References - Names and addresses of a minimum of three (3) individuals who are qualified to provide authoritative information regarding training/experience, current clinical competence, health status, and/or fulfillment of obligations as a Medical Staff member within the privileges requested. At least one of the references must be from the current or most recent employer(s) or institution(s) where clinical privileges are or were held. In the case of individuals completing residencies, one reference must come from the residency training program director. The Facility Director may require additional information.

4) Previous Employment - List of all health care institutions where the practitioner is/was appointed, utilized, or employed including:

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

5) Drug Enforcement Administration (DEA) Registration and State Controlled Substance Certification, if applicable:

   a. Registration must be documented for those who have or have had DEA registration or a state controlled substance certification.
   b. Previously successful or currently pending challenges to DEA registration or state controlled substance certification or the voluntary relinquishment of such registration must be reported.

6) Challenges to license, including whether a license or registration to practice a healthcare occupation ever held by the practitioner has been suspended, revoked, voluntarily or involuntarily surrendered,

or not renewed.

7) Status of any claims made against the practitioner in the practice of any healthcare occupation, if available.

8) Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

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

10) For new appointments, picture identification to ensure that he/she is the individual identified in the credentialing documents.

11) Authorization for release of information, including written consent and release of liability for the inspection of records and documents pertinent to applicant's licensure, training, experience, competence, and health status.

12) National Provider Identifier (NPI) received from National Plan and Provider Enumeration System (NPPES) as mandated by Health Insurance Portability and Accountability Act of 1996 (HIPAA).

13) Background checks in accordance with Human Resources and Office of Personnel Management regulations.

B. Documents required (primary source obtained by the Medical Staff Office) in addition to those listed include:

1) Documentation of current or most recent clinical privileges held, if available.

2) Verification of status of licenses for all states in which the applicant has ever held a license.

3) For foreign medical graduates, evidence and verification of the Educational Commission for Foreign Medical Graduates (ECFMG) certificate and/or a fifth pathway route of training, if claimed.

4) Evidence and verification of board certification, if claimed.

5) Verification of education credentials used to qualify for appointment (and privileges) including all postgraduate training.

6) Evidence of submission of query to National Practitioner Data Bank (NPDB) and for all physicians, screening will be

accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source information from the state licensing board for all actions related to the disciplinary alert as well as a statement from the practitioner is required.

7) Confirmation of health status.

8) Agreement to abide by the Medical Staff Bylaws and Rules and to provide continuous care of applicant's patients.

NOTE: Verification is defined as 'primary source' documentation by letter, telephone call, computer printout, or, in the case of confirmation of board certification, by listing in specific directories. Competence and relevant training or experience will be established through primary source verification. See VHA Directive 1100.19 and VA Handbook 5005, Part II, Chapter 3, Section B.

7.2.2 Burden of Proof

The applicant has the burden of obtaining and producing all needed information for a proper evaluation of 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 45 days of request may serve as a basis for denial of consideration for employment.

7.3 Process and Terms of Appointment

A. Service Chief Recommendation: The chief of the service to which the applicant is to be assigned is responsible for recommending appointment to the Medical Staff based on evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.

B. CMO Review: In order to ensure that 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 ECMS if the response from the NPDB continuous 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 VHA's Electronic Credentialing System 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.

C. ECMS Recommendation: The ECMS recommends Medical Staff appointment based on evaluation of credentials of each applicant.

D. Director Action: Appointments to the Medical Staff should be acted upon by the VANTHCS Director within 30 calendar days of receipt of a fully complete application including all required verifications, references, and recommendations from the appropriate service chief and ECMS.

   The appointment can be effective as of the date signed by the Director, but may not become effective at a date later than 30 calendar days from the date signed by the Director or 45 calendar days after the recommendation of the ECMS.

E. Time periods specified in this section that are created to help those accomplishing the credentialing and privileging process do not imply any rights of the applicant to have his/her application processed within these same time periods.

F. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment. In the case that the appointment is not approved, reasons will be provided.

7.4 Evaluation and Maintenance of Credentials

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

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

copy of diploma, confirmation from someone in practice or training at the same time, is being used in lieu of primary-source verification. The applicant should assist in providing required information for this documentation.

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

C. Maintenance of Files: A complete and current Credentialing and Privileging file including the electronic VHA's Electronic Credentialing System file will be established and maintained for each practitioner requesting privileges. These files will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging. Any time that a credentialing file is found to lack required documentation for any reason, effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the file stating the reason. The entry will also detail the effort made to obtain the information, with dates and signature of the individuals responsible for the effort.

D. Privileges may be reduced or terminated voluntarily at any time, if Medical Staff members make formal requests for such reductions or terminations and give full explanations why such requests should be granted.

ARTICLE 8: CLINICAL PRIVILEGES

8.1 General Provisions

A. VA North Texas Health Care System specific Medical Staff privileges are granted for a period of up to two (2) years.

B. Biennial reappraisal of all practitioners who hold clinical privileges is required and will be accomplished utilizing the VHA's Electronic Credentialing System system. Reappraisal includes a review of performance and an evaluation of the individual's physical and mental status, peer appraisals and assessment of the individual's current privileges. It also requires documented evidence of relevant ongoing continuing medical education (CME). This can include activities pertaining to faculty positions where they serve to advance clinical knowledge and skills. Reappraisal is initiated by the practitioner's service chief at the time of a request by the practitioner for new and renewed clinical privileges.

C. A practitioner's request for modification/enhancement of existing clinical privileges is made by the practitioner's submission of a formal request for a desired change(s) with full documentation to support the change. Current written information (evidence-based evaluation of competence) may be used for evaluation of requests for additional privileges. Modification of privileges will be accomplished utilizing the VHA's Electronic Credentialing System

system as done at the time of reappointment. A Focused Professional Practice Evaluation is required for all new privileges granted to a practitioner.

D. Other licensed practitioners (associate health professionals), who are presently permitted by law and VANTHCS to provide patient care services may be granted a scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence

E. Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.

F. Practitioners with clinical privileges are assigned to and have clinical privileges in one clinical department/service, but may be granted clinical privileges in other clinical departments/services.

G. Exercise of clinical privileges within any service is subject to the rules of that service and to the authority of that service chief.

H. When certain clinical privileges are contingent upon appointment to the faculty of affiliates, loss of faculty status results in termination of those privileges.

I. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies. This includes the option of "privileging by proxy" in accordance with VHA policy and Joint Commission standards. When this option is utilized, the facility may use the credentialing and privileging decision from the site providing care if the provider is fully credentialed and privileged at that site and a formal agreement is in place, i.e., a Memorandum of Understanding which outlines the arrangement including services to be received and bilateral communication of quality of care concerns, including at minimum, all adverse outcomes.

J. Tele-consultation: All Practitioners providing tele-consultation services are subject to existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

Note: Gender, race, creed, and national origin will not be used in making decisions regarding granting or denying of clinical privileges.

8.2 Process and Requirements for Requesting Clinical Privileges

A. Burden of Proof – When additional information is needed, the practitioner

requesting clinical privileges must furnish all information needed for a proper evaluation of professional competence, conduct, ethics, and other qualifications. The information must be complete and verifiable. The practitioner is responsible for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of request may serve as a basis for denying clinical privileges.

B. A practitioner's request for clinical privileges must be made in writing and include privileges requested "within well-defined limits" (e.g., procedure/disease classifications) in a format approved by the Medical Staff. Typically, this request comes from the clinical service chief under whom the practitioner will be working and is given to the Credentialing office.

C. Initial Privileges: The practitioner applying for initial clinical privileges must submit a complete application that includes:

1. Complete appointment information as outlined in Article 7.

2. Application for clinical privileges.

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

4. 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 facility.

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

6. 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. These must be made within 15 days of the adverse action.

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

8. 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.

9. Prior to assuming clinical duties, new providers must supply evidence of current certification in BLS and/or ACLS as required by VHA Policy.

Provider must maintain certification in order to continue provision of clinical duties as required by VHA Policy.

10. Bylaws Receipt and Pledge. Prior to the granting of clinical privileges, Medical Staff members or applicants will receive a copy of the Bylaws and sign an electronic pledge, as stated in the on-line VHA's Electronic Credentialing System credentials application, agreeing to provide for continuous care of their patients and to abide by the professional obligations therein.

Verification: Before granting initial clinical privileges, the Medical Staff Office will ensure that the following information is on file and verified with primary sources, as applicable:

1. Verification of credentials prior to granting of initial privileges willbe accomplished as described in Article 7.

2. Before granting clinical privileges, the Chief of Staff will ensure thatthe 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, when applicable

   c. National Practitioner Data Bank Continuous Query Registration and when applicable, FSMB query.

   d. Physical and mental health status information from applicant

   e. Physical and mental health status confirmation by aphysician designated by, or acceptable to, the facility

   f. Professional competence information from peers

   g. Continuing education

   h. Board certification(s), if applicable

   i. Quality of care information

D. Renewal of Privileges: The Practitioner applying for renewal ofclinical privileges must submit the following information:

1. Complete appointment information as outlined in Article 7.

2. Application for clinical privileges.

3. Supporting documentation of professional training and/or experience not previously submitted.

4. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges, confirmed by a physician acceptable to the Organized Medical Staff.

5. Documentation of continuing medical education related to area and scope of clinical privileges, not previously submitted.

6. 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.

7. 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. These must be made within 15 days of the adverse action.

8. 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 Staffmember within the privileges requested.

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

11. Bylaws Receipt and Pledge: Prior to the renewal 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. This attestation must be made in VHA's electronic credentialing system before the provider can submit their application for appointment or privileges.

Verification: Before granting renewal of clinical privileges, the Medical Staff Office will ensure that the following information is on file and verified with primary sources, as applicable:

1. Current and previously held licenses in all states.

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

3. National Practitioner Data Bank Continuous Query Registration.

4. FSMB query, when applicable and if there was a break between recredentialing cycles.

5. Physical and mental health status information from applicant.

6. Physical and mental health status confirmation by a physician designated by, or acceptable to, the facility.

7. Professional competence information from peers and Service Chief, based on results of ongoing professional practice monitoring and FPPE.

8. Continuing education to meet any local requirements for privileges requested.

9. Board certifications, if applicable.

10. Quality of care information.

E. Increase or Modification of Clinical Privileges: Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur. Practitioners are encouraged to consider carefully and discuss appropriateness of specific privileges with the appropriate service chief prior to formal submission of the request.

The process for ""Renewal of Clinical Privileges" above will be followed for practitioners applying for clinical privileges subsequent to those granted initially; however, in addition to these requirements, the practitioner is also required to provide full documentation to support the change in privileges.

Administrative Modifications (reduction) of privileges should be pursued when a Practitioner is changing their clinical duties at the facility so that their current privileges reflect current expected practice. Examples would be a change of position, facility no longer providing identified procedures, closure of a clinical program, or low volume and no expectation to perform procedure in the foreseeable future. These modifications are administrative in nature and are not to be considered adverse action thus they are not reportable to NPDB. Initiation of an Administrative Modification may be made by the Practitioner or the Facility. The change should be supported by the service chief and reported to the ECMS for concurrence. The provider should be notified in writing of the Administrative Modification to include the specific privileges being administratively reduced, the reason, and confirmation that the action is not considered adverse or reportable. This should not be utilized if there is concern of the Practitioner's clinical practice. Clinical concerns must be addressed through other procedures outlined in this document.

8.3 Recommendations and Approval

A. Peer recommendations will be obtained from individuals who can provide authoritative information regarding training/ experience, professional competence, conduct, and health status. Peer recommendations should include written information regarding the practitioner's current:

1. Medical/Clinical Knowledge
2. Technical and Clinical Skills
3. Clinical Judgment
4. Interpersonal Skills
5. Communication Skills
6. Professionalism

B. The service chief to whose service the applicant for clinical privileges is assigned is responsible for assessing all information, both initially and for reappraisal, and recommending approval of clinical privileges. This responsibility includes queries to all other facilities where the practitioner has held or holds privileges.

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

2) Recommendation for clinical privileges subsequent to those granted initially will be based on, at least, reappraisal of physical and mental health status, peer recommendations from two (2) peers of the same specialty (other than the Service Chief), continuing education, professional performance, judgment and clinical and/or technical skills, and service specific provider profile information. Service specific profile may include, but is not limited to, appraisal of technical skills, quality of care including results of monitoring, performance improvement activities, evaluation activities such as surgical case review, drug usage evaluation, medical record review, blood usage review, pharmacy and therapeutics review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, customer satisfaction, consult usage, infections, mortality, restraint usage, moderate sedation, utilization management, autopsy, aggregate practitioner data as applicable, and clinical service and/or facility monitors. The Clinical Service Chief and, if applicable, the Clinical Section Chief will complete the "Assessment by Section and Service Chief for Renewal of Clinical Privileges" attestation page that denotes a provider's current competence and performance activities during the past renewal cycle. It also requires documentation of continuing medical education that complies with state licensure renewal requirements. For providers with little to no VA patient activity during their reprivileging cycle, letters of recommendation in the form of a

competency questionnaire will be sent to the department chairs or Service Chiefs at other facilities where the provider has privileges.

C. The ECMS recommends the granting of clinical privileges based on each applicant having successfully met the requirements for clinical privileges as specified in these Bylaws.

D. The application for appointment and clinical privileges are acted upon by the VANTHCS Director within 30 days of receipt of the ECMS recommendation to grant/deny the requested privileges and appointment as recommended. The Director's action must be verified with an original signature.

E. Original approved clinical privilege documents are placed in the individual practitioner's Credentialing and Privileging folder and copies are distributed to the practitioner.

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

8.4 Ongoing Professional Practice Evaluation (OPPE)

A. OPPE allows the Medical Staff to identify, on an ongoing basis, professional practice trends that may impact quality of care and patient safety. Each service will define specific criteria relevant to that service and will maintain an up-to-date OPPE file on each credentialed provider (and those functioning under an approved scope of practice). Specific criteria should include (but not be limited to):

1. Quality of patient care
2. Medical/clinical knowledge
3. Practice-based learning improvement
4. Interpersonal communication skills
5. Professionalism
6. Systems based practice

B. OPPE data must be aggregated and may come from a variety of sources consisting of, but not limited to, data that are not integrated into performance improvement activities. Indicators will be developed by the services and approved by the ECMS, to include consideration and monitoring of the following areas, if applicable:

1. Appraisal of technical skills
2. Blood usage
3. Consult usage

4. Continuing medical education
5. Customer satisfaction/complaints
6. Infections
7. Medical records completion
8. Moderate sedation
9. Mortality rates
10. Operative and other procedures performed and their outcomes
11. Peer recommendations
12. Peer reviews (now called clinical pertinence reviews for service level monitoring and not to be confused with Protected Peer Review conducted by Clinical Quality Management)
13. Performance improvement activities
14. Requests for tests or procedures
15. Resident supervision
16. Restraint usage
17. Resuscitations
18. Risk management
19. Tort claims filed, reports to the National Practitioner Data Bank, non-VA claims paid
20. Training and mandatory testing
21. Utilization management

C. In using aggregate data, the service chief will compare the individual practitioner against the aggregate, when feasible (i.e., data that are not collected for the specific purpose of specific care issues or resource utilization). Data will be collected by each service by means such as a review by peers of medical records, direct observation, monitoring of diagnostic and treatment techniques and may also include collection of information from other members of the health care team. Data on provider workload and provider practice patterns will also be available by downloading a provider's profile via a VistA software program.

D. Data on each provider will be reviewed by the service chief or his/her designee and will include aggregate data, when appropriate, for the comparison of providers with their peers.

D. Documentation of OPPE for each provider will be maintained by the service and will include service derived data as well as other information provided semiannually.

E. Thresholds will be established for each indicator in order to help facilitate identification of abnormal practice trends. When thresholds are exceeded, a defined process for evaluation will result as delineated in the "thresholds" attachment to VANTHCS Memorandum No. 11-11 "Ongoing Professional Practice Evaluation".

8.5 Focused Professional Practice Evaluation (FPPE)

A. FPPE is a defined, time-limited process whereby the organization evaluates the privilege-specific competence of practitioners who do not have documented evidence of competency performing privileges they have requested at this organization or when there is a question regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process also extends to physician extenders functioning under an approved Scope of Practice. FPPE will be undertaken in the following circumstances:

1. On all newly hired clinical practitioners.

2. When there is a question regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This may arise as result of review of OPPE data, reports of contact, clinical pertinence review results, risk management activities, observation by other employees, executive concerns, or any source where evidence of clinical practice is monitored.

3. For all new privileges requested, unless otherwise recommended by ECMS and approved by the Director.

4. When there is a sentinel event associated with a specific practitioner, a serious practitioner specific complaint, a provider-specific tort settlement, significant safety violation, or repeated or egregious unprofessional behavior.

5. When the Peer Review Committee's threshold for a service-specific FPPE referral is met.

6. When a provider returns to duty after an extended absence of greaterthan nine months from clinical activity.

The complete FPPE process is further outlined in VANTHCS Memorandum No. 11-03 "Focused Professional Practice Evaluation".

8.6 Additional Privileges

A. Practitioners who have completed required training in new procedures outside VANTHCS must submit, in writing, a request for approval to perform the new procedure. The written request must include copies of documentation of training and a letter from the course proctor stating the completion date of training and number of cases performed. Once thewritten request has been received by the Medical Staff Office, the process for renewal of clinical privileges for the provider will be initiated and completed as described in Section 8.2 above. The written request must be approved by his/her section chief and/or service chief, ECMS, and the VANTHCS Director. FPPE will be initiated at the beginning of performance of the new privilege at VANTHCS.

B. Proctors from outside VANTHCS providing in-service training are required to submit, in writing, a request for temporary privileges. In addition, practitioners undergoing in-service training must submit, in writing, a request for an amendment to their clinical privileges showing these procedures to be performed under supervision. Once the training has been completed, the trainee must follow the procedure outlined in paragraph A above.

C. The ECMS, Clinical Service Chiefs, the Chief of Staff, and/or the Director of VANTHCS reserve the right to recommend denial of additional privileges if evidence exists that the resources to adequately care for patients under the conditions of these additional privileges do not exist or if the privileges are not required for the position held.

8.7 Exceptions

8.7.1 Expedited Appointment

There may be instances in which expediting a medical staff appointment for licensed independent practitioner (LIP) is in the best interest of high quality patient care. Requirements for expedited appointment are as follows:

a. The Practitioner must submit a completed application through VHA's Electronic Credentialing System.

b. The Health Care System:

(1) Verifies education and training;

(2) Verifies one active, current, unrestricted license from a State, Territory, or Commonwealth of the United States or the District of Columbia;

(3) 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;

(4) Queries licensure history through the Federation of State Medical Boards (FSMB) Physician Data Center and receives a response with no report documented;

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

(6) Verifies current comparable privileges held in another institution; and

(7) Receives a response from Continuous Query registration with no match.

(8) Verifies that there are no current or previously successful challenges to licensure.

(9) Verifies that there is no history of involuntary termination of medical staff membership at another organization.

(10) Verifies that there is no history of voluntary limitation, reduction, denial, or loss of clinical privileges.

(11) Verifies that there is no history of final judgments adverse to the applicant in a professional liability action.

c. A delegated subcommittee of the ECMS consisting of at least two voting members of the full committee recommends appointment to the medical staff.

d. The recommendation must be acted upon by the Director.

e. Full credentialing must be completed within 60 calendar days of the date of the Director/Governing Body signature and presented to the ECMS for ratification.

8.7.2 Temporary Privileges

When there is an emergent or urgent patient care need, temporary clinical privileges may be granted at the time of an initial appointment for a limited period of time (not to exceed 60 calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff. Verification of one active, current, unrestricted license with no current or previously successful challenges to licensure, confirmation of possession of clinical privileges comparable to those to be granted, response from a NPDB query with no match, response from FSMB with no reports (if applicable), and a reference will be obtained prior to making such an appointment.

Examples of when a temporary medical staff appointment for urgent patient care needs may be made are:

1. Situations in which a physician becomes ill or takes a leave of absence and a LIP would be needed to cover the physician's practice until the physician returns.

2. Situations in which a specific LIP with specific skills is needed to augment the care to a patient that the patient's current privileged LIP does not possess.

Temporary privileges are based on verification of the following:

a. One, active, current, unrestricted license with no previous or pending actions.

b. 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.

c. Current comparable clinical privileges at another institution.

d. Response from NPDB-HIPDB PDS Continuous Query Registration with no match.

e. Response from FSMB with no reports.

f. No current or previously successful challenges to licensure.

g. No history of involuntary termination of medical staff membership at another organization.

h. No voluntary limitation, reduction, denial, or loss of clinical privileges.

i. No final judgment adverse to the applicant in a professional liability action.

A completed application must be submitted within three calendar days of temporary privileges being granted and credentialing completed.

8.7.3 Teleconsultation and Telemedicine Privileges

When utilizing TJC accredited hospitals or ambulatory care organizations for telemedicine or teleconsultation, VANTHCS may use the credentialing and privileging decision from the site providing the care if :

a. The practitioner is appropriately credentialed and privileged to provide this care at the site providing the telemedicine or teleconsultation; and

b. A formal agreement (e.g. memorandum of understanding (MOU), contract, sharing agreement, etc.) is in place between the two organizations. This agreement defines that:

a. The facility accepting these telemedicine or teleconsultation services (the site of the patient) has evidence of internal reviews of the practitioner's performance of those privileges and reports to the distant site (the site of the practitioner delivering the services) any quality of care concerns that are useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes.

b. The facility providing these services will report to the facility receiving the services any quality of care concerns that occur. At a minimum, this information includes all adverse outcomes.

2. For VA purposes, telemedicine providers must have a medical staff appointment in at least one VA medical facility. This requirement will assure that the telemedicine provider is credentialed and privileged in accordance with VA standards. This facility where the telemedicine provider is credentialed and privileged will serve as a TJC accredited entity for the purposes of this process. Even though other VA entities may be utilizing the services of the telemedicine provider through MOU, contract, or other agreement with a non-VA entity, a MOU with the VA medical facility serving as TJC accredited entity is required.

3. In the case of contract practitioners, it should be noted that some states do not allow telemedicine and/or teleconsultation across state lines, unless the provider is licensed in the state where the patient is physically located. VHA has a General Counsel opinion from 2006 that indicates that in these states, the clinical indemnity coverage of contract practitioners may be void, even if they are credentialed and privileged by VA. Prior to the commencement of services by the contract practitioners providing telemedicine and/or teleconsultation or remotely monitoring physiology data from veteran patients, the state regulatory agency in the state in which the practitioner is physically located as well as the state where the patient is physically located, must be consulted. When dealing with Federal entities, additional licenses that authorize the provision of telemedicine and/or teleconsultation services in the relevant states may not be required. The opinion of the Regional Counsel must be sought in these matters.

8.7.4 Disaster Privileges

Disaster privileges may be granted when the facility has activated the emergency management plan and is unable to handle the immediate patient needs. Disaster privileges will be granted under the provisions of VHA Handbook 1100.19. Full reference is also in the Emergency Operations Plan (EOP).

A. Responsibilities

The Director, or the Director's designee, is responsible for ensuring all procedures outlined under this section are followed for all providers receiving disaster privileges. All disaster privileges will be granted by the Director or the Director's designee.

The Chief of Staff is responsible for ensuring that the required credentialing information for disaster appointment is received and/or verified for all licensed independent providers as required by VHA directives prior to the assignment of emergency/disaster responsibilities.

The Service Chief is responsible for assigning a current staff provider within the same discipline to each provider receiving voluntary disaster assignments in their service. The assigned staff provider is responsible for overseeing the activities of the provider receiving a voluntary disaster assignment.

The Medical Staff Office is responsible for completing credentialing and issuing the provider receiving a voluntary disaster assignment an Emergency Credentials ID Badge at the time the disaster privileges are approved.

B. Response Procedures

1. Temporary disaster assignments will be granted to an appropriately qualified provider, based upon the needs of the health care system to augment staffing due to the disaster situation. Assignments will be approved by the Director; however, if the Director is unavailable, approval may be granted by the Incident Commander under the ICS (AD). Approvals will be documented in writing and retained with the service.

2. The verification process at the time disaster privileges are granted must include:

   a. A current hospital photo identification card and evidence of current license to practice, or

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

   c. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by federal, state or municipal entity.

3. Photocopies of the above-listed documents will be made and retained. The Medical Staff Office will complete the HCS Disaster Credentialing Form and attach to the front of the photocopies.

4. Upon approval of the disaster assignment, the volunteer provider will be issued an ID badge by the Medical Staff Office that identifies that person as a volunteer provider.

5. Status and location of each volunteer provider will be tracked and maintained in the Medical Staff Office, in conjunction with the service under which the volunteer has an assignment.

6. The volunteer provider will be assigned to a member of the health care system's staff, in the same discipline, who will serve as a mentor and oversee his or her professional performance through direct observation and/or clinical record review. The mentor will be responsible for completing an evaluation of the provider and recommending continuation of the volunteer provider disaster privileges within 72 hours from the time the provider presented to the organization for disaster assignment.

7. The Medical Staff Office will verify current comparative privileges and competence with hospital affiliations and will initiate primary source verification of licensure as soon as the immediate situation is under control. Primary source verification of licensure must be completed within 72 hours from the time the volunteer provider presents to the organization. The Chief of Staff will report any irregularities to the Service Chief under which the volunteer provider is assigned. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (for example, if there is no means of communication or there is a lack of resources), it is expected that it will be done as soon as possible. In this situation there must be documentation of:

   a. Why primary source verification could not be performed in the required timeframe.

   b. Evidence of demonstrated ability by the volunteer provider to continue to provide adequate care, treatment and services.

   c. An attempt to rectify the situation that prevented the accomplishment of primary source verification.

   d. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) would not be required if the volunteer provider has not provided care, treatment, and services under the disaster responsibilities and is confirmed as such by the responsible Service Chief.

8. Disaster credentialing will initially be granted for 72 hours or for the duration of the disaster situation, whichever is shorter. At the conclusion of the 72-hour period, the organization will make a decision on the continuation of the disaster assignments for an additional 7 calendar day timeframe. This discussion will be based on the results of verifications and the evaluation and recommendation of the volunteer provider's mentor. In the event that verification, observation or other information gathered reveals questionable information about the qualifications of the provider and/or the mentor's recommendation, concurred by the Service Chief and Director or their designees, is for disapproval of assignment, the assignment will be immediately terminated. The form shown in Attachment B will be completed

and utilized for the review process and documentation of the decision to grant or not grant initial and continued disaster assignment.

9. The specified period of time under which these health care professionals granted disaster appointment and privileges may practice on these disaster privileges may not exceed 10 calendar days or the length of the declared disaster, whichever is shorter. At the end of this period the provider needs to be converted to a temporary appointment and temporary privileges defined by VHA Directive or relieved. The provider must submit a complete application within 3 calendar days of the date the appointment is effective.

10. Full credentialing must be accomplished within 60-days from the date of the temporary/urgent appointment. If unfavorable information is discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

8.7.5 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. Properly supervised members of the house staff may also provide emergency care. Once imminent danger has passed, the care of the patient should be transferred as appropriate.

8.7.6 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. Inactivation of privileges for this purpose is administrative and should only be done when there is no concern of substandard care, professional misconduct, or professional incompetence.

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

2. The inactivation should be reported for informational purposes to the ECMS with confirmation that the inactivation was not due tosubstandard care, professional misconduct, or professional incompetence.

3. At the time of inactivation of privileges, including separation from the medical staff, the Facility Director ensures that within 7 calendar days of the date of separation, information is received suggesting that the Practitioner met generally accepted standards of clinical practice and

there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.

8.7.7 Deployment and Activation Privilege Status

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

and Reemployment Rights Act of 1994.

1. Facility staff request that a Practitioner returning from active duty communicate with the Facility staff as soon as possible upon returning to the area.

2. 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.

3. 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. The verified credentials, the Practitioner's request for returning the privileges to an Active Status, and the Service Chief's recommendation are presented to ECMS for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the ECMS 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. The service chief and Medical Executive Committee should consider if a routine FPPE should be implemented to monitor the provider's practice depending upon the length of time away from the facility.

4. 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.

5. 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.

6. 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.

7. If the file cannot be brought to a verified status and the Practitioner's privileges restored by the Director, the Practitioner can be granted a Temporary Appointment to the Medical Staff not to exceed 60 calendar days during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VHA's

Electronic Credentialing System:

a. 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.
b. Registration with the NPDB-HIPDB PDS Continuous Query with no match.
c. A response from the FSMB with no match, if applicable.
d. Marking of the Temporary Enrollment Screen as reinstatementfrom Deployment and/or Activation.
e. Documentation of the Temporary Appointment on theAppointment Screen not to exceed 60 calendar days.

ARTICLE 9: INVESTIGATION, SUMMARY SUSPENSION AND PRIVILEGING ACTIONS

This article addresses the process to be used when the potential for a clinical care concern has been identified for providers who have been granted clinical privileges. This section does not apply to individuals who are on Scopes of Practice. Those individuals will be managed through a similar process with Human Resource Services. This article defines the steps to be used to gather information of the concern, the employee's clinical job duties and subsequent action to be taken when appropriate.

9.1 Concerns Identified

A. Whenever there are concerns that a practitioner with delineated clinical privileges has demonstrated substandard care, professional (clinical) misconduct, or professional (clinical) incompetence, further information will be gathered to either confirm or refute the legitimacy of the concerns. The individual's immediate supervisor will typically be the individual responsible for conducting a preliminary review of the alleged clinical deficiencies to determine whether a comprehensive focused clinical care review or other administrative review is warranted. The Chief of the practitioner's clinical service, the Chair of ECMS, the Chief of Staff or the Medical Center Director may also initiate a preliminary fact-finding.

B. Whenever a preliminary fact-finding confirms a concern considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Behavior or Behaviors that Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, further review of the concerns may result in a fact-finding, administrative investigation, or comprehensivefocused clinical care review. These findings may result in an administrative action.

1. Material that is obtained as part of a protected performance improvement activity (i.e., 38 U.S.C. 5705) may not be used to support an administrative action although performance improvement data, such as that obtained as

a result of an Ongoing Professional Practice Evaluation (OPPE), may trigger a more comprehensive review of the Practitioner's work.

2. Quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705. Therefore, if such information is necessary in order to conduct a review of the alleged professional deficiencies and any action resulting from the review, it must be developed through mechanisms independent of the performance improvement program, such as a fact-finding, a comprehensive focused clinical care review, an administrative investigation, etc.

C. Summary Suspension of Privileges: The Director has the authority, whenever immediate action must be taken in the best interest of patient care due to the potential of imminent danger to the health and well-being of an individual, including the Practitioner, to summarily suspend all or a portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Medical Center Director. The typical process to be followed in order to summarily suspend a Practitioner's privileges is as follows (for information about the Automatic Suspension of Privileges, see section 9.4):

1. The Chief of Staff will make a recommendation to the Medical Center Director that a summary suspension of all or part of the Practitioner's privileges be invoked because the failure to take such action may resultin an imminent danger to the safety and welfare of an individual.

2. The Medical Center Director will approve the request, if appropriate, and the Practitioner will be issued a notification letter that all or part of the Practitioner's clinical privileges are suspended and include the general reason that the action being taken. For physicians and dentists, this notice will also include information in regards to the requirement to report the individual to the National Practitioner Data Bank (NPDB) if the Practitioner should retire or resign prior to the conclusion of the clinical review and any action resulting from those findings being imposed. (*NOTE:* Management's decision to take a Practitioner out of patient care or place a Practitioner in an authorized leave status due to patient care concerns will result in a summary suspension of clinical privileges being imposed, as the underlying reason for such action is due to concerns about the imminent danger to the health or well-being of an individual. In this case, a summary suspension of clinical privileges letter must be issued to the Practitioner immediately.) The letter also notifies any Practitioner who is summarily suspended that information gathered during the review may be used in reporting to their respective State Licensing Board(s).

3. Immediately upon the imposition of a summary suspension, the Service Chief or the Chief of Staff will ensure that alternate medical coverage for the Practitioner's patients is provided.

4. The written notification of summary suspension of clinical privileges may afford the Practitioner of the opportunity to submit, within 14 calendar days from receipt of the summary suspension notification letter, a written response to the concerns identified within the letter.

5. If the Practitioner provides a written response, the Medical Center Director will determine whether or not the summary suspension of privileges should continue to be imposed pending the outcome of the comprehensive clinical review and any further action imposed as a result of the review. If the decision is made to continue the summary suspension of privileges, the Practitioner's response to the identified issues will be shared with the individual(s) conducting the review of the clinical concerns.

D. Administrative Denial of Privileges Pending the Outcome of an Investigation

1. If a Practitioner's privileges are due to expire during a Summary Suspension, they must still be asked to submit information required for recredentialing and request all privileges that were held prior to the Summary Suspension. Failure to request all privileges previously held will be considered a voluntary relinquishment of privileges during an investigation and may be reportable to the NPDB if the Practitioner is a physician or dentist.

2. The service chief and Executive Committee of the Medical Staff may recommend an Administrative Denial of Privileges Pending the Outcome of an Investigation rather than recommending the granting or denial of privileges before all relevant information to make such a determination is available.

3. The Practitioner will be notified in writing of the decision to administratively deny the privileges pending outcome of the investigation. The notification will also inform the provider that they remain under investigation and that this action is not reportable to NPDB as it is an administrative action and not "for cause".

4. The Practitioner's privileges will lapse on the expiration date (cannot be extended for any reason) and the Practitioner will not hold privileges at this facility until the Investigation has concluded and there is a decision based upon the outcome as to whether the requested privileges will be granted or denied.

5. An administrative denial of privileges may be taken on one or more privileges depending upon the circumstances. If the summary suspension was not for all privileges, the recommendation may be to grant select privileges and administratively deny those that under investigation.

6. If the requested privileges are subsequently denied after the Investigation has concluded, subsequent appointment and Human Resource actions will be considered accordingly.

9.2 Review Process

A. When sufficient evidence exists, based on the preliminary fact finding, that a Practitioner may have demonstrated substandard care, professional misconduct or professional incompetence that impacts the Practitioner's ability to deliver safe, high quality patient care, the Chief of Staff will normally appoint one or more impartial clinical care reviewers to complete a comprehensive focused -clinical care review of the concerns(s) or issues(s). The clinical care reviewers may be from other VHA healthcare facilities as required for involvement of a peer of same specialty with similar privileges and to ensure objectivity in the review.

B. The Chief of Staff will determine the appropriate methodology and membership for conducting a review. The individual(s) tasked with performing this review must conduct it in a fair and objective manner, and may be selected from the Practitioner's facility or another facility at the discretion of the Chief of Staff and/or Medical Center Director.

C. If the Practitioner is not summarily suspended, as indicated in section C of this Part, the Practitioner will be issued a letter informing the Practitioner that he/she is under Investigation and notifies the Practitioner that if he/she resigns or retires while the review is being conducted, the Practitioner may be reported to the National Practitioner Data Bank (NPDB).

D. The individual(s) who conducts the comprehensive focused clinical care review have the discretion to meet with the Practitioner to discuss or explain the clinical care concerns. This meeting does not constitute a Hearing and none of the procedural rules set forth in Article 10 of these Bylaws apply thereto. An investigation initiated at the direction of the Chief of Staff is an administrative matter and not an adversarial Hearing. A record of such meeting is made and included with the reviewer's findings, conclusions and recommendations reported to the ECMS.

E. The comprehensive focused clinical care review is typically completed within 30-calendar days, but may be extended if circumstances warrant a longer review period. Documentation in support of an extension should be maintained, and the Practitioner should be notified on regular intervals of the status of the review. The Practitioner being investigated will be apprised of the extension.

F. The reviewer(s) may review any documentation needed to fully assess the issues (except for those exempt in paragraph 2 above) and/or interview witnesses, including the Practitioner. The reviewer(s) should be asked if the

provider met the standard of care (yes or no) and if not, why the standard was not met.

G. The report of the comprehensive focused clinical care review will be made to the ECMS within 14 calendar days after the reviewers have completed the investigation. The ECMS will assess the results and make a recommendation to the Medical Center Director regarding the appropriate action to be taken. The ECMS has the discretion to meet with the practitioner within 10 calendar days after receipt of the evidence to ask him/her questions about the findings before reaching a conclusion regarding their recommendations. The ECMS is not required to meet with the practitioner, and if the practitioner fails to meet with the ECMS within a reasonable period of time, which is typically 14 calendar days after the meeting is requested, the ECMS must submit its recommendation for action without the practitioner's input. This proceeding does not constitute a hearing, and there is no entitlement to any procedural rules set forth in Article 10 of these Bylaws or any other VA regulations. The ECMS is not required to share the report or any supporting documentation in advance of the proceeding or during the proceeding with the practitioner. A record of such proceedings will be made and included with the reviewers' findings, conclusions and recommendations that are submitted to the Director.

9.3 Recommendations Following the Review

A. The ECMS can make the following recommendations to the Directorbased on the evidence gathered before, during, and after the review:

   a. No action;

   b. Initiation of a Focus Professional Practice Evaluation (FPPE) for cause;

   c. Revocation of privileges; or

   d. Reduction in privileges.

B. Within five (5) business days, the Medical Center Director will reviewthe recommendation of the ECMS and forward it to the Chief of Staff for appropriate administrative action, if applicable.

C. <u>No action:</u> If the Medical Center Director concurs with the ECMS's recommendation for no action, the practitioner will be notified in writingwithin five calendar days and, if applicable, notified that privileges are restored.

D. <u>FPPE for Cause:</u>

   1. If the recommendation is for FPPE for Cause to be initiated, privileges will be reinstated upon the creation and issuance of the FPPE for Cause. The

FPPE for Cause will provide appropriate notification to the Practitioner of the areas of weakness and develop a plan under which the Practitioner can improve in order to successfully complete the FPPE for Cause by demonstrating the requisite skill and knowledge in those areas of clinical issues identified as a concern. (*NOTE:* FPPE for Cause will normally be for a minimum of 60-90 calendar days. In general, extension of the FPPE for Cause is discouraged.)

2. Upon completion of the FPPE for Cause, results will be reported backto the ECMS.

3. FPPE for Cause is an opportunity for the privileged practitioner to demonstrate competency and improved performance. It is not an adverse action, is not considered an investigation, and is not reportable as an adverse action to the National Practitioner Data Bank. If the Practitioner is unable to demonstrate competency and improved performance, the FPPE for Cause may be stopped at any point by the supervisor to ensurepatient safety and an adverse privileging action may result.

E. Revocation of Privileges:

1. If the ECMS recommends that the Practitioner's privileges be revoked, or if a Practitioner fails an FPPE for Cause and the ECMS subsequently recommends the revocation of privileges, the Chief of Staff will assess the evidence and coordinate the separation of the Practitioner with Human Resources Management Service, unless management offers the practitioner a position at the facility that does not require the Practitionerto have clinical privileges.

2. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed removal and proposed revocation of privileges in accordance with VA Handbook 5021, Part II, unless other separation procedures under VA Handbook 5021, Part VI are applicable. If the Practitioner is separated and the Practitioner's privileges are revoked for issues involving professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board, if applicable.

3. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a)(1), the Medical Center Director will issue a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of the right to a fair hearing after the separation is imposed in accordance with Article 10 of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation is due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB.

The hearing will not serve as an appeal to be reemployed by the agency.

4. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the procedures in VA Handbook 5021, Part III will be followed unless other separation procedures under VA Handbook 5021, Part VI are applicable. If the Practitioner is separated following these procedures, the Practitioner will be afforded the opportunity for a fair hearing after the separation is imposed in accordance with Article 10 of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation is due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

5. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for revocation of clinical and privileges and the need to remove the Practitioner from the facility. The Practitioner will be separated and subsequently notified of the right to a fair hearing after separation in accordance with Article 10 of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation is due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reappointment to the medical center.

F. Reduction of Privileges:

1. If the ECMS recommends that the Practitioner's privileges be reduced, or if a Practitioner fails an FPPE and the ECMS subsequently recommends the reduction of privileges, the Chief of Staff will assess the evidence and coordinate the reduction of the Practitioner's privileges with Human Resources Management Service.

2. If the Practitioner is appointed as a full-time permanent employee under the provisions of 38 U.S.C. 7401(1), the Chief of Staff will issue a proposed reduction of privileges and proposed reduction in grade or basic pay in accordance with VA Handbook 5021, Part II, if the Practitioner's change in privileges will result in a reduction in grade or basic pay. If the Practitioner's grade or basic pay and privileges are reduced for issues involving professional conduct or competence, the Practitioner will be afforded the opportunity to file a proper appeal to a Disciplinary Appeals Board.

3. If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a)(1), the Medical Center Director must determine if the Practitioner's services are still needed given the reduction in privileges.

   a. If it is determined that the Practitioner's services are still needed,

management will follow the procedures for modifying a Practitioner's privileges.

b. If the Practitioner's services are no longer needed, the Practitioner will be issued a discharge notice in accordance with VA Handbook 5021, Part VI, unless other separation procedures under VA Handbook 5021 are applicable. The Practitioner will subsequently be notified of right to a fair hearing after separation in accordance with Article 10 of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation is due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

4. If the Practitioner is a full-time employee serving a probationary period under 38 U.S.C. 7403, the Practitioner may be assigned to duties that do not require a reduction in grade or basic pay or the procedures in VA Handbook 5021, Part III will be followed, unless other separation procedures under VA Handbook 5021, Part VI are applicable. (***NOTE:*** Probationary employees cannot be issued a major adverse action, and thus suspension, transfer of function, or reduction in grade or basic pay is not an option.) If the Practitioner is separated, he/she will be afforded the opportunity for a fair hearing after separation in accordance with Article 10 of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation is due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. The hearing will not serve as an appeal to be reemployed by the agency.

5. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for reduction of clinical and privileges. If the Practitioner's services are no longer needed, the Practitioner will be separated from the contract and will subsequently be notified of the right to a fair hearing after separation in accordance with Article 10 of these Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation from the contract is for substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB. If it is determined that the Practitioner's services are still needed, management will notify the Practitioner of the right to a fair hearing of the reduction of clinical privileges in accordance with Article 10 of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the reduction is due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB.

9.4 Automatic Suspension of Privileges

A. An Automatic Suspension occurs immediately upon the occurrence of specific events.

1. The medical staff membership and clinical privileges of any practitioner with delineated clinical privileges shall be automatically suspended if any of the following occurs:

    a. The practitioner is being investigated, indicted, or convicted of a misdemeanor or felony that could impact the quality of care or safety of patients.

    b. The Practitioner is being investigated for conduct or behavior issues that do not have an impact on patient care, but management has determined it could negatively impact the work environment.

    c. The practitioner is being investigated for fraudulent use of a Government credit card.

    d. The practitioner fails to maintain the mandatory requirements for membership of the medical staff.

    e. The Practitioner being on leave for an extended period of time, as deemed warranted by ECMS.

2. In addition to those listed above, automatic suspension of clinical privileges shall occur whenever the license (or equivalent legal credential) of a Medical Staff member is revoked or restricted, or if the individual fails to renew the professional license prior to expiration. The automatic suspension shall be for the same time period that such license (or equivalent legal credential) is suspended. No right to a hearing or appellate review exists under these conditions.

3. Automatic suspension of the right to prescribe medications covered by Drug Enforcement Agency (DEA) number will occur whenever a DEA number is revoked or suspended. The Medical Staff member is immediately and automatically divested of any right to prescribe covered by the DEA number. No right to a hearing or appellate review exists under this condition.

4. For matters requiring further investigation, the Chief of Staff convenes the Ad Hoc Investigative Team to investigate the matter and to make a report thereof to the ECMS within fourteen (14) days, unless clinical review cannot be obtained within this timeframe, after the effective date of the Automatic Suspension. For matters not requiring further investigation, a report will be made to ECMS.

5. Immediately upon the occurrence of an Automatic Suspension, the Service Chief or the Chief of Staff will provide or assign alternate medical coverage for the patients of the suspended Practitioner.

6. If there is more than one automatic suspension 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.

9.5 Actions Not Constituting Corrective Action

The comprehensive clinical care reviewers responsible for conducting reviews are not deemed to have proposed 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 under Article 10 or a Disciplinary Appeals Board (DAB) will not have arisen in any of the following circumstances:

1. The appointment of an ad hoc committee investigation committee;

2. The conduct of an investigation into a matter;

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

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

5. 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;

6. Corrective counseling;

7. A recommendation that the Practitioner be directed to obtain retraining, additional training, continued education, or placement on FPPE; or

8. 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 10: FAIR HEARING AND APPELLATE REVIEW

10.1 Reduction of Privileges

10.1.1.1 Proposing a Reduction of Privileges

a. Prior to any action or decision by the Director regarding reduction of privileges, that does not also involve a major adverse action, such as a suspension, reduction in grade, or reduction in basic pay, as defined in VA Handbook 5021, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

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

   2. A statement of the practitioner's right to be represented by counsel or a representative of the individual's choice, throughout the proceedings.

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

c. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the practitioner disagrees with the Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within five (5) business days after receipt of decision of the Director.

d. A proposed action to reduce a practitioner's privileges will be made in accordance with VHA Handbook 1100.19. In instances where reduction of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code, the proposed reduction of privileges will be combined with a major adverse action (e.g. suspension, reduction in basic pay, reduction in grade, transfer, etc.) in accordance with Section 7461 7464 of Title 38, United States Code and VA Handbook 5021 Employee/Management Relations. *NOTE:* A major adverse action may not be proposed against a 38 U.S.C. Section 7403 or Section 7405 (except nurses) employee, or a contractor.

10.1.1.2 Convening a Panel

a. A panel is not convened if a reduction in clinical privileges is combined with a major adverse action, such as a suspension, reduction in grade, or a reduction in basic pay, due to substandard care, professional misconduct or professional incompetence. A reduction in basic pay may occur when a physician's salary is reduced by a pay panel as a result subsequent to a reduction in privileges. In those instances, the proposed reduction and proposed major adverse action are taken together in accordance with the provisions of VA Handbook 5021, Part II.

b. In the case of a reduction in clinical privileges that does not constitute a major adverse action or is not combined with a major adverse action in accordance with VA Handbook 5021, the facility Director must appoint a review panel of at least three unbiased professionals within 5 business days after receipt of the Practitioner's request for a hearing. These professionals 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 process must be conducted on the basis of the record. The hearing will proceed as follows:

1. 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 business days and not more than 30 business days from the date of the notification letter.

2. During such hearing, the practitioner has the right to:

   a) Be present throughout the evidentiary proceedings;

   b) Be represented by an attorney or other representative of the Practitioner's choice. *NOTE: If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses;* and

   c) Cross-examine witnesses.

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

b. The panel must complete the review and submit the report within 15 business days from the date of the close of the hearing. The

panel may request in writing that the facility Director grant additional time due to extraordinary circumstances or cause.

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

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

e. If the Practitioner wishes to appeal the Director's decision, the Practitioner may appeal to the appropriate VISN Director within 5 business days 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 will be withdrawn.

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

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

g. The hearing panel chair will:

1. 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.

2. 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.

3. Maintain decorum throughout the hearing.

4. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the

admissibility of evidence.

5. 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.

6. Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.

7. Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

10.1.1.3 Practitioner's Rights

a. The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, (provided that this representative does not have a conflict of interest) cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

b. The Practitioner may submit a written appeal to the VISN Director within 5 business days of receipt of the Director's decision, if he/she is in disagreement with the decision rendered.

c. If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, including by resignation or retirement, while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

10.2 Revocation of Privileges

A. Revocation of privileges refers to the permanent loss of all clinical privileges. Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures in accordance with VHA Handbook 1100.19, and the following regulations are applicable:

B. In instances where revocation of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code, 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.

1. For probationary employees appointed under 38 U.S.C. 7401(1) and part-time temporary registered nurses appointed under 38 U.S.C.

7405, the Professional Standard Board (PSB) will convene in accordance with the procedures outlined in VA Handbook 5021, Employee/Management Relations. If separation is recommended and the recommendation from the PSB is based in whole, or in part, for reasons of substandard care, professional incompetence, or professional misconduct, the Director, or designee, may separate the Practitioner as prescribed in VA Handbook 5021. Separation constitutes an automatic revocation of clinical privileges, which is reportable to the NPDB, if the Practitioner is a physician or dentist, but only after being afforded due process. All practitioners, whether reportable to the NPDB or not, are entitled to due process.

2. In instances where the Practitioner is appointed through a contract or other "at will" appointment, including but not limited to part-time (excluding part-time temporary registered nurses who are covered under the procedures in para 5(a)(ii), fee basis, without compensation, or intermittent appointment, separation may occur immediately, but separation constitutes an automatic revocation of clinical privileges and is reportable to the NPDB if the Practitioner is a physician or dentist, and the revocation is for substandard care, professional incompetence, or professional misconduct. A report to the NPDB may not be filed until the Practitioner has been afforded a limited fair hearing to determine if the resulting revocation of privileges was due to substandard care, professional misconduct, or professional incompetence. The contractor has no other right to appeal.

B. Revocation procedures will be conducted in a timely fashion. Revocation of clinical privileges may not occur unless the Practitioner is also discharged, separated during probation, or the appointment is terminated. However, 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 Practitioner is a physician or dentist and the revocation of privileges and subsequent reassignment constitutes a major adverse action due to a reduction in grade or basic pay, or for reasons of substandard care, professional incompetence, or professional misconduct (e.g., a surgeon's privileges for surgery may be revoked, and the surgeon may be reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility). Any recommendation by the ECMS 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 Section 10.1 of this Article.

10.5 Reporting to the National Practitioner Data Bank

Disclosure of information to the National Practitioner Data Bank will follow provisions of VHA Handbook 1100.17, entitled "National Practitioner Data Bank Reports (NPDB)".

A. Tort ("malpractice") claims are filed against the United States government, not individual practitioners. There is no direct financial liability for named or involved practitioners. Government attorneys (Regional Counsel, General Counsel) consider the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.

B. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioners should be reported to the NPDB. The review must determine that there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.

C. Practitioners are also identified and notified at the time a tort claim is filedso that they may assist Regional and General Counsel in defending the case and in decisions concerning denial or settlement.

D. Post payment reviews are performed nationally by the office of Medical-Legal Affairs. Accordingly, a letter is now sent to physicians involved in the plaintiff's case when a tort claim settlement is submitted for review.

E. VA only reports adverse privileging actions that adversely affect the clinical privileges of Physicians 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 bereported.

10.6 Reporting to State Licensing Boards

A. 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 ofclinical practice as to raise reasonable concern for the safety of patients. Disclosure of information to State licensing boards regarding practitioners will be completed in accordance with VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards.

10.7 Management Authority

A. Nothing in these procedures restricts the authority of management to detailor reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of anyproposed

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

10.8 Impaired Provider

A. VANTHCS provides for a mechanism to educate and address the Medical Staff about licensed independent practitioner health issues, address prevention of physical, psychiatric, or emotional illness and to facilitate confidential diagnosis, treatment, and rehabilitation of those practitioners who suffer from a potentially impairing condition. See VANTHCS Memorandum No. 11-09, "Management of Impaired Independent Practitioner" for further details.

ARTICLE 11: CONFIDENTIALITY

11.1 General Provisions

Section 5705, Title 38, United States Code was enacted to protect the integrity of the VA's medical quality assurance program by making confidential and privileged certain records and documents. Disclosure of records and documents made confidential and privileged by regulations may be made only in accordance with the provisions stated therein. Disclosure of records and documents that are not confidential and privileged by 38 U.S.C. 5705 will be governed by provisions of the Freedom of Information Act, the Privacy Act, HIPAA, and/or other VA confidentiality statutes.

11.2 Breach of Confidentiality

Peer Review, review of Staff qualifications, and the evaluation of quality of care in any format provided at VANTHCS depend upon professional, open, and candid, but confidential, discussions. Any breach of confidentiality of related records, discussions, or deliberations of the Medical Staff or ECMS or their committee reports, is considered outside appropriate standards of conduct. Breach of confidentiality will also be considered detrimental to the quality of patient care and will be subject to any adverse actions as allowed by VHA and VANTHCS policies, rules, and regulations.

ARTICLE 12: AMENDMENTS AND BIENNIAL REVIEWS

The Bylaws and Rules 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 and Rules and attendant policies may be submitted in writing to the Chief of Staff by any service chief or member of the Medical Staff. The Chief of Staff will coordinate and distribute proposed draft amendments to the members of the ECMS for review. Changes to the bylaws are amended, adopted and voted on by the Active Medical Staff as a whole, and then approved by the Director. A period of not less than 15 calendar days will be allowed for receipt of written comments from the Active Medical Staff on proposed amendments. The Bylaws are amended and adopted by 2/3 endorsement of the Active Medical Staff.

The ECMS may provisionally adopt, and the Director may provisionally approve, urgent amendments to the Bylaws/Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the Medical Staff. After adoption, these urgent amendments to the Bylaws and Rules will be immediately communicated back to the Medical Staff for retrospective review and comment on the provisional amendment. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article 3, Section 5 should be followed.

All changes to the Bylaws and Rules require action by both the Active Medical Staff and VANTHCS Director. Neither may amend unilaterally.

Changes are effective when approved by the VANTHCS Director.

ARTICLE 13: ADOPTION

These Bylaws, together with the appended Rules below, will be adopted upon recommendation of the Active Medical Staff at any regular or special meeting or by electronic vote by Active Medical Staff at which a quorum is present. They will replace any previous Bylaws and Rules and will become effective when approved by the VANTHCS Director.

Recommended: _____ 12/31/19
Jeffrey Hastings, MD, Chief of Staff — Date

Approved: _____ 12/31/2019
~~Kendrick Brown, Interim Director~~ — Date
Stephen R. Hott, MD
Director

MEDICAL STAFF RULES

I. GENERAL

A. The Rules and Regulations relate to the role and/or responsibility of members of the Medical Staff and individuals with clinical privileges in the care of inpatients (acute and long-term care), urgent care patients, home-based patients, and ambulatory care patients with different levels of acuity and needs in various settings throughout VANTHCS. Rules and regulations are issued by the Department of Veterans Affairs within the matrix of VA handbooks, manuals, directives, etc., which are elaborated in local system policy and procedures that are available to the Medical Staff. The following VANTHCS rules and regulations serve the Medical Staff to help them and guide them to provide the highest quality of medical care.

B. Rules and Regulations of services will not conflict with each other, with bylaws, rules, and policies of the Medical Staff, or with requirements of the Governing Body.

C. Each Medical Staff member shall be responsible for carrying out these rules and regulations to assure compliance with the standards of TJC and the rules of the Department of Veterans Affairs.

II. PATIENT RIGHTS

A. Patient Rights and Responsibilities

VANTHCS supports the rights of each patient. Specific details of these rights and of patient responsibilities can be found in VANTHCS Memorandum No. 00-01, "Patient and Nursing Home Resident Rights and Responsibilities".

B. Living Will/Advance Directive/Withholding and Withdrawal of Life-Sustaining Treatment

It is the policy of VANTHCS to follow the patient's or surrogate decision maker's request to participate in health care decisions. Information on Living Wills/Advance Directives may be found in VANTHCS Memoranda Nos. 11-05, "Withholding or Withdrawal of Life Sustaining Treatment" and 122-04, "Advance Directives Documentation and Implementation". An Ethics Consult should be requested in any situation that is unclear or for which the provider needs guidance.

C. Informed Consent

1. The Medical Staff will support the right of each patient to informed consent for treatments and procedures in accordance with TJC guidelines, VA directives contained within VHA Handbook 1004.01 "Informed Consent For Clinical Treatments and Procedures" and VANTHCS Memorandum No 11-04 "Informed Consent for Clinical Treatments and Procedures."

2. Informed consent should:

a. Be consistent with legal requirements and ethical standards (e.g. potential conflict of interest where the clinician is also the researcher).

b. Be documented in the medical record before commencement of the procedure or treatment for which it is required. See VANTHCS Memorandum No 04D-09, "Authorization for Medical Record Entries & Document Completion Requirements."

3. Informed consent will be in accordance with VANTHCS Memorandum No 11-04 "Informed Consent for Clinical Treatments and Procedures". The informed consent will be completed in its entirety, i.e., including all signatures (patient, physician, and witness when applicable).

4. Submission of surgical specimens will be in accordance with the published current VANTHCS Pathology and Laboratory Medicine Service Lab Manual.

D. Adverse Event Disclosure

Information on adverse event disclosure can be found in VANTHCS Memorandum 00CQM-10, "Adverse Event Disclosure".

E. Pain Management

The Medical staff will support the rights of each patient to have his/her pain screened, assessed and treated. When appropriate, a pain treatment plan is documented with adequate and appropriate interventions and/or medication in accordance with the Department of Veterans Affairs Policy as outlined in VANTHCS Memorandum No 112A-01, "Pain Management."

F. Ethical Dilemmas

Ethics Consultation Service is available to respond to specific ethics questions or to requests for general information, policy clarification, document review, discussion of hypothetical or historical cases, or analysis of organizational ethics questions.

G. Organ/Tissue Donation

Patients or their legal next-of-kin have the right to donate organs/tissue if they choose to do so. All deaths in the hospital should be considered for possible organ/tissue donation according to the established criteria as described in VANTHCS Memorandum No 112-06 "Organ Donation and Donation of Body for Science."

H. Human Research

Patients have the right to agree to participate in research and, at the same time, they have the right to know that research requirements have been followed. VANTHCS is responsible for the protection of research subjects from undue risk and from deprivation of personal rights and dignity. This protection is best ensured by consideration of two issues, which are the touchstone of ethical research. (Reference: Program for Protection of Human Research Subjects at VANTHCS (Seventh Edition):

1. That voluntary participation by the subjects, indicated by free and documented informed consent, is ensured; and
2. That an appropriate balance exists between potential benefits of the research to the subject or to society and the risks assumed by the subject.

III. GENERAL RESPONSIBILITY FOR CARE

A. Conduct of Care

1. Management of the patient's general medical condition will be the responsibility of a qualified physician member of the Medical Staff. Licensed advanced practice registered nurses or certified physician assistants with an approved Scope of Practice will be assigned a primary physician supervisor.

2. A uniform quality of patient care will be expected of all individuals with delineated clinical privileges within and across services and among all staff members who have clinical privileges.

3. A comparable standard of quality of surgical and anesthesia care will be expected in all areas where such services are offered.

B. Emergency Services

1. VANTHCS maintains an Emergency Department under the management of the Emergency Medicine Section of Medical Service that offers emergent care services 24 hours a day. At least one physician experienced in emergency care will be on duty at all times, and specialty consultation will be available within approximately 30 minutes by members of the Medical Staff or by Residents under their supervision.

2. All ill or injured patients who come into VANTHCS for emergency medical evaluation or initial treatment will be assessed by a qualified Medical Staff member.

3. Specialty consultation in the Emergency Department is available by request of the attending Medical Staff member or by transfer to a designated hospital where definitive care can be provided.

4. Written policies and procedures specifying the scope and conduct of patient care provided by Emergency Department are maintained in the office of the Chief of Emergency Medicine Section of Medical Service.

5 Applicants without emergent/urgent medical needs or without legal eligibility for care at VHA facilities will be offered Social Work Service assistance in locating health care resources available in the community.

C. Admissions

1. General Provisions

a. Only a physician or dentist member of the Medical Staff may admit a patient to VANTHCS.

b. Except in an emergency, no patient will be admitted to VANTHCS until a provisional diagnosis has been entered into the medical record.

c. All inpatients will be attended by a member of the Medical Staff and will be assigned to the service or section appropriate for the treatment of the disease that necessitated hospitalization.

d. The Staff Oral and Maxillofacial Surgeon will be responsible for services rendered by the oral surgery staff. Dental or oral surgical procedures performed in the surgical suite will be under the overall supervision of the Chief, Surgical Service.

e. A patient medical history and physical examination will be completed and documented in the medical record in accordance with timeframes noted in VHA Policy, State laws, and regulations by the attending physician, dentist, or oral/maxillofacial surgeon, as appropriate.

f. When such history and physical examination is not recorded before the time stated for operation, the operation will be canceled or delayed unless the surgeon states in the medical record that such delay would constitute a significant hazard to the patient.

g. Inpatients that are referred to Dental Service for dental procedures will receive the same basic medical appraisal as patients admitted to other clinical services. Physician members of the Medical Staff may be consulted regarding medical problems that may be present or may arise during hospitalization. Dentists are responsible for that part of their patient's history and physical examination related to dentistry.

2. Procedures

Patients will be assigned to the direct care or supervision by a Medical Staff

member who is responsible for medical care and treatment, supervision of Residents and Students, prompt completion of an accurate medical record, special instructions to the patient, and transmitting reports on the condition of the patient to the referring practitioner and family members.

3. Tests

a. Diagnostic tests will not be initiated automatically on the patient atthe time of admission unless pre-determined as a Performance Measure process (such as an EKG).

b. In appropriate diagnostic situations, the Medical Staff member will obtain voluntary informed consent of the patient prior to testing as outlined in VANTHCS Memorandum No. 11-04 "Informed Consent for Clinical Treatments and Procedures."

Note: Per VHA Handbook 1004.01 Informed Consent for Clinical Treatments and Procedures, requirement for written consent for HIV testing has ceased effective August 17, 2009.

D. Areas of Restricted Admission

1. Medical Intensive Care Unit/Cardiac Intensive Care Unit (MICU/CCU)

a. The Chairman, Critical Care Committee, maintains responsibility to optimize and standardize patient care for issues relating to the MICU/CCU and SICU/TICU, including quality assurance and for issues relating to the Code Blue and Rapid Response Teams.

b. Written criteria for admission to the MICU/CCU are outlined in Medical Service Standard Operating Procedures Memorandum No. 111-23 (Policies of the Coronary Care/Medical Intensive Care Unit).

c. Multi-system failure will be managed by the primary cardiovascular or pulmonary services. Other medical subspecialties may be consulted as appropriate to assist in patient management.

d. The Director, MICU, and the Director, CCU, are responsible for administrative issues relating to non-cardiac and cardiac issues, respectively.

2. <u>Surgical Intensive Care Unit/Thoracic Intensive Care Unit (SICU/TICU)</u>

a. Written criteria for admission to the SICU/TICU are outlined in "Discharge Guidelines for patients admitted to the Surgical Intensive Care Units (SICU's) at VANTHCS".

b. Consultation with the attending intensivist and/or the ICU resident on call

(under the supervision of a staff physician) is required when patients are admitted to the SICU. The General Surgery Chief Resident or Cardiothoracic Fellow will help triage patients to be discharged to the floor whenever there are no ICU beds available. The General Surgery Chief Resident and the Cardiothoracic Fellow will follow the patient in their respective units until the patient is transferred out.

c. All critically ill patients are under the joint care and management ofthe intensive care team and the unit/admitting team. Appropriate consultations with other services (Cardiology, Neurology, Pulmonary, Renal, etc.) may be requested.

d. The Directors of the SICU and TICU maintain ultimateadministrative responsibility for issues relating to the SICU/TICU.

E. Transfers

1. Policies and procedures governing the transfer of patients to and from the MICU/CCU and SICU/TICU are outlined in VANTHCS Memorandum No. 139-07, "Inter-Facility Transfer Policy", Medical Service Standard Operating Procedure Memorandum No. 111-23 (Policies of the Coronary Care/Medical Intensive Care Unit), and "Discharge Guidelines for patients admitted to the Surgical Intensive Care Units (SICU's) at VANTHCS" respectively.

2. Transfer of a patient to VANTHCS from another health care facility is usually arranged in order to obtain continued or specialized treatment. Under no circumstances will a patient be accepted for transfer until the referring physician has discussed the patient's care with the accepting staff physician and an agreement has been reached to accept the patient at that time. There must be agreement that the patient is identified as "stable" for transport. Judgment will be exercised to meet the medical needs of the patient during transfer.

3. When a patient is accepted for transfer, the accepting and transferring physician or their designee should agree on and record specific information on VA Form 10-2649A, Inter-Facility Transfer Form, and VA Form 10-2649B, Patient Consent to Transfer. Both forms will be filed in the medical record and scanned into CPRS.

4. Per VHA directive, transport is the responsibility of the sending hospital. Transfers will not be made at VA expense merely to comply with the wishes of a patient, a family member or other interested person, except as stated in subparagraph 5 below.

5. A hospitalized patient who develops a need for treatment that VANTHCS is not staffed or equipped to provide may be transferred to another VAmedical center or to a non-VA hospital that has adequate facilities and staff. Preference will be given to using another Federal Government facility or a

non-VA hospital with which VANTHCS has entered into a sharing agreement. Transfer to a non-VA hospital is restricted to those VA beneficiaries developing a bona fide medical emergency that precludes moving the patient to another VA medical center or other Federal Government facility. Patients transferred to non-VA hospitals in accordance with the provisions of M-1, Part I, Chapter II will be returned as soon as practicable to VANTHCS to recover.

6. Patients transferred to another VA facility may be returned to VANTHCS for continued care when medically indicated. VANTHCS will provide a bed for the return of a transferred patient when mutually agreeable between the facilities involved and when the best interest of the patient will be served.

7. A veteran with a terminal illness and a probable life expectancy of limited duration (weeks or months) who requires continuing hospital or nursing home care, may be transferred to a suitable VA medical center nearer the veteran's home. Transportation for such transfers will be at VA expense if the veteran meets the basic eligibility criteria as provided in M-1, Part I, Chapter II for payment or reimbursement of beneficiary travel expense.

8. The patient's Medical Staff attending physician will determine and document the need for any special care to be provided during transfer. If possible, travel arrangements will be made to permit arrival at VANTHCS during the regular administrative workday prior to 2:00 p.m.

9. When a transfer patient is escorted by a VA employee or authorized attendant, copies of the consolidated health record and diagnostic images will be placed in the custody of the escort to accompany the patient. If the patient is required to transport medical records, these will be transported in a locked bag. When a transfer patient is not to be escorted, the records and x-rays will be mailed or sent by courier service to the receiving facility to arrive before the patient. If the patient is likely to arrive at the receiving facility before the records, appropriate identification and treatment information will be telephoned or faxed in advance. Rules for protection of private patient information will be followed.

10. Transportation that is to be at government expense must be coordinated through the Travel Office during regular hours. After regular working hours transfers will go through the ER physician, who must medically justify the need for transport. The AOD and Bed Control staff must be integrally involved to assure a smooth transfer.

F. Consultations

1. Required Consultations:

Except in an emergency, consultation with another qualified physician is required when the patient's physician or dentist judges that:

a. A patient's condition warrants a medical risk assessment prior to consideration for an operation, invasive procedure, or medical treatment.

b. The diagnosis is obscure.

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

2. **Consultant**:

A consultant must be well qualified to give an opinion in the field of his/her specialization. The qualifications and privileges of the consultant are determined by the Medical Staff on the basis of an individual's training, experience, and demonstrated competence.

3. **Essentials of a Consultation**:

A satisfactory consultation includes review of the medical record and examination of the patient by the attending physician. An opinion signed by the consultant must be included in the medical record in accordance with timeframes noted in VHA Policy, State laws, and regulations. When operative procedures are involved, the consultation note, except in an emergency, will be recorded and signed prior to the operation.

4. **Responsibility for Requesting and Furnishing Consultations**:

The patient's physician or dentist shall be responsible for requesting consultation. The chief of service will ensure that all requests to his/her service for consultation are answered timely.

G. Discharge Planning

1. Discharge planning is an ongoing, interdisciplinary process beginning prior to admission for scheduled admissions and at the time of admission for unscheduled (urgent or emergent) admissions. The processes involved in the facility's discharge planning policy are described in VANTHCS Memorandum No. 139-02 "Discharge Policy".

a. Patients who do not have serious or chronic illness and who have a good social support system and adequate financial resources will usually manage their own discharge planning and will not require a physician's referral of the case to Social Work Service.

b. Some patients, in adjusting to the effects of illness, will have family, financial, health compliance, or other problems. These patients should be identified by the physician and referred to Social Work Service as soon as possible. This will ensure that discharge planning is not delayed or compromised.

c. A significant number of patients are "high risk" because they present complex discharge and aftercare problems. They may have chronic or life-threatening illnesses; histories of multiple admissions; or inadequate financial, housing, or relationship resources. It is important that the physician identify these patients as quickly as possible so that the intricacies of discharge planning can be addressed as rapidly and energetically as possible well prior to anticipated discharge. High risk factors may include:

Age 80 or older
AIDS/HIV positive
Homelessness
Loss of caretaker
Recurrent or metastatic malignancy
Suicide attempt
Readmission within seven days of discharge
Heart failure

d. Patients not deemed "high risk", who have a good prognosis and good social support systems, will not usually require social work services. A social worker will be available if the patient's condition or situation deteriorates. In such cases, Social Work Service will develop and coordinate a plan in consultation with the interdisciplinary team caringfor the patient.

2. Nursing staff will initiate discharge planning at the time of admission, and will follow physician's discharge instructions. If home health care is anticipated, the physician will submit a Geriatrics and Extended Care (GEC) or hospice/palliative care referral as early in the hospitalization as possible to allow timely processing.

3. Physicians, nurses, case managers, social workers, dietitians, chaplains, psychologists, audiologists, speech pathologists, and rehabilitation services staff are available to meet patient needs. Referral to the OEF-OIF-OND Program Coordinator will be made for all eligible veterans. Applicable Clinical Reminders will be completed prior to discharge.

4. Discharge will be documented in the medical record with a discharge summary completed (signed) and available for review in CPRS in accordance with timeframes noted in VHA Policy, State laws, and regulations.

H. Discharge

1. General Provisions for Discharge from Hospital

a. Patients will be discharged only on a written order of the physician or dentist and the discharge summary will be completed (signed) and

available for review in CPRS in accordance with timeframes noted in VHA Policy, State laws, and regulations. As per VANTHCS Memorandum No. 139-02 "Discharge Policy" patients discharged from VANTHCS also require, as appropriate, orders for referrals, transportation, equipment, supplies (including home oxygen), medication, follow-up appointments, medication reconciliation, etc.

b. Physician/Dentist Discharge Orders are completed in the Computerized Patient Record System (CPRS). The physician/dentist electronic signature activates the CPRS discharge orders. Discharge medication prescriptions, prosthetic requests, and requests for travel are activated through CPRS, and requests are filled when discharge orders are released. Delayed CPRS orders will not be activated until released by the physician/dentist. The Clerk and/or Nursing staff are responsible for verifying all orders written by the physician in CPRS by placing their initials into the appropriate CPRS header. The Clerk schedules routine primary care follow-up appointments. Referrals to specialty clinics require a CPRS consult to the appropriate clinical specialty by the physician/dentist.

c. Patients who are dependent upon home nursing or other assistance (e.g. oxygen) will not be discharged until it is ensured that their care outside of VANTHCS will be adequate.

2. **MICU/CCU**:

Discharge from the MICU/CCU to a lower level of care or to home will be considered based on the MICU/CCU discharge criteria (updated yearly). Discharge criteria are only guidelines for discharge. An attending Intensivist may discharge patients he/she deems appropriate for discharge.

3. **Post-anesthesia Care Unit (PACU):**

Discharge from the PACU for patients post general anesthesia, regional anesthesia, or Monitored Anesthesia Care (MAC) typically will be based on the "Post Anesthesia Care Unit Policy and Procedure Manual PACU Discharge Criteria". These criteria may be modified depending on the individual patient. "Discharge" refers to patient relocation to a less intensive setting, e.g., regular nursing unit. Patients not meeting discharge criteria after an appropriate stay in PACU, or when indicated, will be relocated to an ICU area. Discharge criteria are only guidelines for discharge. An attending Anesthesiologist may discharge patients he/she deems appropriate for discharge to the appropriate unit.

4. **Surgical Intensive Care Unit (SICU)/Thoracic Intensive Care Unit (TICU)**:

Discharge from the SICU/TICU will be typically based on consideration of the SICU/TICU "Discharge Guidelines for patients admitted to the Surgical

Intensive Care Units (SICU's) at VANTHCS". Discharge criteria are only guidelines for discharge. An attending Intensivist may discharge patients he/she deems appropriate for discharge.

5. **Against Medical Advice:**

Should a patient leave against medical advice, this will be documented in the medical record and the patient will be requested to sign the appropriate document.

I. **Patient Death**: In the event of death, the patient will be pronounced dead by a licensed physician or specially trained Registered Nurse (Long Term Care). The body will not be released until there is an appropriate medical record entry by a licensed physician. Policies with respect to the release of a patient's body will conform to VHA, Federal, and Texas State regulation.

J. **Autopsy**

1. **General Provisions:**

In the interest of improving patient care and professional knowledge, every member of the professional staff is expected to actively participate insecuring permission for autopsies in all deaths. Special effort will be made to secure an autopsy in accordance with the criteria noted in VANTHCS Memorandum No. 11-15, "Post Mortem Examination". Autopsies will be performed only by Pathology and Laboratory Medicine Service (P&LMS) staff.

2. **Consent for Autopsy:**

Consent for autopsy will be obtained by signature of the legal next-of-kin on the appropriate form, SF-523, including any limitation on the scope of the autopsy imposed by the next-of-kin.

3. **Request for Autopsy:**

The physician staff will provide information regarding clinical diagnosis and concerns to the P&LMS staff prior to the autopsy, specifically including any infection hazards. Request for autopsy will be fulfilled as soon as the following requirements are met:

a. The hospital death does not constitute a County Medical Examiner's Case. See VANTHCS Memorandum No. 11-15, "Post Mortem Examination".

b. If the death is a County Medical Examiner's Case, it has been reported by a physician and released by the Medical Examiner's office with a "No Case" or "Form-16" number recorded in the CPRS note and on the consent form.

c. Authorization for autopsy, SF-523, is completed and bears the signature of the next-of-kin, the physician, and two medical center employee witnesses. See VANTHCS Memorandum No. 11-15, "Post Mortem Examination".

d. Autopsies are performed between the hours of 8:00 a.m. and 3:00 p.m., Monday - Saturday and on an emergency basis on Sundays, holidays or after hours if necessary, in consultation with the pathologist on call. Autopsies authorized after 3:00 p.m. are performed the next morning.

K. Surgical and Cytology Specimens

1. All tissue, including teeth and foreign bodies, or other specimens removed from patients will be referred to P&LMS for processing and examination.

2. Surgical and cytology specimens will be examined and diagnostic reports issued of the findings upon accurate completion of a Tissue Examination Form (SF 515) that should accompany every appropriately labeled specimen.

3. Tissue diagnoses from surgical and cytology specimens will be used as a source of clinical information in quality assessment and management activities.

4. VA pathologists must review and issue a report on the slides or other pathologic materials for all surgical or cytology specimens obtained outside VA that are used as a basis for treatment or surgery.

IV. PHYSICIAN ORDERS

A. General Requirements

1. All physician, podiatrist, chiropractor, or dentist orders for diagnostic, therapeutic, or medication interventions must be entered directly into CPRS.

2. Treatment orders will be entered and signed only by House Staff and Medical Staff members within the authority of their clinical privileges or scope of practice, or by other healthcare personnel pursuant to pertinent VANTHCS policies.

B. Medication Orders

1. All medication orders, with the exception noted below, must be electronically entered into CPRS and must include date, time, medication, dose, route, timing of administration, and signature of the physician/prescriber. Medication orders written by Physician Assistants, CRNAs, or Clinical Pharmacy Specialists with proper authorization must be co-signed by a provider

licensed to prescribe medications in accordance with timeframes noted in VHA Policy, State laws, and regulations, unless co-signature is not required under the relevant scope of practice.

2. **Personal Medications**:

Medications brought to VANTHCS by a patient and kept in VANTHCS after the patient is admitted will be sent to Pharmacy Service for safe-keeping or destruction. See VANTHCS Memorandum No. 119-10, "Disposition of Drugs Brought to the Medical Center by Patients upon Admission", for additional information.

3. **Bedside Medications**:

a. Medications are authorized for bedside use only for self-medication programs approved by the Pharmacy and Therapeutics Committeewhen ordered by the responsible physician.

b. Labels for bedside medications are required as follows:

1. The manufacturer's label is adequate on over-the-counter (OTC) drugs.

2. All other bedside medications must be ordered by the prescriber indicating "for bedside use" and entered directly into CPRS. The label on the medication should be processed by the Pharmacy.

c. Bedside medications will be given in accordance to VHA Policy, State laws, and regulations.

4. **Prescription Forms:**

Prescription orders will be entered directly into CPRS VA Form 10-2577F, Security Prescription Form, or VA Form 10-1158, Doctor's Orders may be used for all other prescriptions only when the provider does not have computer access or while CPRS is not available. All medications, general medical supplies, and outpatient pharmacy-related prosthetic devices/supplies for specific patient use will be ordered in this manner. *Exception: all outpatient Schedule II narcotics require a hard copy VA Form 10-2577F.* VANTHCS Memorandum No. 119-16, "Control of VA Form 10-2557F, Prescription Forms" covers all procedures related to this topic.

C. Automatic Stop Orders

Guidelines for Automatic Stop Orders are outlined in VANTHCS Memorandum No.119-01, "Drug Policy and Procedures".

D. Verbal or Telephone Orders

Verbal and telephone orders are used only in cases of emergent or urgent situations in which evaluation or treatment of clinical situations must beaddressed promptly but in which the provider does not have ready access to CPRS. This process must follow TJC "write down, read back" methodology, although, in some emergent situations, a verbal "repeat back" is acceptable. Verbal or telephone orders for diagnostic or therapeutic interventions may be accepted by a Registered Nurse (RN), Certified Respiratory Therapy Technician (CRTT), or Clinical Pharmacy Specialist (CPS). The order will include date, time, name of the ordering physician and full name and title of the RN, CRTT, or CPS. Full procedural guidelines can be found in VANTHCS Memorandum No. 118A-10, "Verbal and Telephone Orders". Orders for Total Parenteral Nutrition (TPN), Chemotherapy, and DO NOT RESUSCITATE (DNR) cannot be accepted verbally or by telephone.

E. Order Sets

Collections of orders that facilitate a specific patient care activity will be approved individually by the respective clinical service chiefs. Each component order will be displayed in CPRS for review and signature by the ordering clinician. Order sets will be revised as appropriate by each service.

F. Investigational Drugs

An investigational drug for clinical use is one for which a sponsor has filed and has approval for an investigational new drug (IND) application with the Food and Drug Administration. Use of an IND in clinical research must be conducted according to a protocol approved by the Institutional Review Board (IRB) and the Research and Development Committee (RDC) of VANTHCS. The wisdom and sound professional judgment of the investigator, the staff, and the Research and Development Committee collectively will determine what constitute the rights and welfare of human subjects in research and what constitute risks and potential medical benefits of the use of a particular drug and/or investigational device or procedure. Necessary for consideration of a protocol by the RDC are the protocol of the study; a Lay Summary and Consent Form (VA Form 10-1086) specific to the study; a copy of VA Form 10-1086, Agreement to Participate in Research by or Under the Direction of the Department of Veterans Affairs, indicating the title of the study and signed by the investigator; and VA Form 10-9012, Investigational Drug Information Record, for each drug in the study. Additional information on the use of investigational drugs may be found in VANTHCS Memorandum No. 151-01, "Investigational Drugs".

G. Informed Consent

Information on informed consent may be found in VANTHCS Memorandum No. 11-04 "Informed Consent for Clinical Treatments and Procedures".

H. **Submission of Surgical Specimens** - All tissue (including teeth) and foreign

bodies removed in the Operating Room or other clinical unit will be sent to P&LMS for examination and specific processing considered necessary to arrive at a pathological diagnosis.

I. Special Treatment Procedures

1. **Do Not Resuscitate (DNR) Orders:** This policy is outlined in VANTHCS Memorandum No. 11-06, "Do Not Resuscitate (DNR) Orders Do Not Intubate (DNI) Orders".

2. **Advance Directive:** This policy is outlined in VANTHCS Memorandum No. 122-04 "Advance Directives Documentation and Implementation".

3. **Withholding or Withdrawal of Life-Sustaining Treatment:** This policy is outlined in VANTHCS Memorandum No. 11-05, "Withholding or Withdrawal of Life Sustaining Treatment".

4. **Physical Restraint and Seclusion** - This policy is outlined in VANTHCS Memorandum No. 118A-11, "Physical Restraint and Seclusion".

5. **Emergency Detention and Court Ordered Treatment**

   a. The Medical Staff will comply with the Mental Health Code of the State of Texas in matters of court-ordered treatment and emergency detention of patients.

   b. VANTHCS is capable of providing care for patients under a court order for Mental Health Treatment. However, VANTHCS is not able to accept patients brought to the facility for emergency detention under a Mental Illness Warrant.

   c. Patients requiring court ordered treatment are processed through the Dallas County Mental Illness Court.

   d. The ACOS for Mental Health is responsible for coordinating activities relating to court-ordered mental health treatment.

6. **Impaired Mentation: Patients under the Influence of Drugs or Alcohol**

   a. A person presenting to the Emergency Department apparently under the influence of drugs or alcohol will be evaluated for the presenting complaint. If a medical problem exists, that problem will be treated appropriately.

   b. If the person becomes combative, he/she will be restrained, if necessary, to prevent injury. Side rails should be up at all times.

   c. If the patient is combative, procedures found in VANTHCS Memorandum

No. 116A-05 "Violent Behavior Prevention Program" will be followed. Emergency Department personnel should be cautious about making diagnostic assumptions about intoxicated patients. When possible, all patients under the influence of drugs or alcohol should be put in a gown in order to facilitate a complete physical examination.

d. If an intoxicated patient is discharged from the Emergency Department, or leaves against medical advice (AMA), and Emergency Department personnel perceive a probability of imminent physical injury to the patient, or to others, the patient should be released only to a responsible adult friend or family member who agrees to drive the patient home and keep him/her under observation. If no responsible parties are available, law enforcement personnel should be notified of the imminent danger in order to check or restrain the patient. Special consideration should be given to holding the patient in the ED for observation, when possible, if unable to find someone to whom the patient can be released.

e. Alcohol addicted patients will be referred to Mental Health Triage.

f. Drug addicted patients will be referred to:

1. Mental Health Triage, or
2. Greater Dallas Council on Alcohol and Drug Abuse

g. If the physician believes it would be dangerous for an incompetent patient to leave the Emergency Department, a request can be madefor the psychiatrist on call to reevaluate the patient.

7. **Patients with Suicidal Ideation:** This policy is outlined in VANTHCS Memorandum No. 116A-01, "Suicide Prevention, Assessment, and Management".

V. SUPERVISION OF TRAINEES (HOUSE STAFF, RESIDENTS, AND NON-PHYSICIANS)

A. Supervision of Resident Physicians/Dentists

1. For VANTHCS policy and complete procedures on Resident Supervision, see VANTHCS Memorandum No. 141-02, "Resident Supervision".

2. Medical Staff members who choose not to participate in the teaching program will not be subject to denial or limitation of privileges for this reason alone.

B. Non-Physician/Dentist Members of the Medical Staff under a scope of practice are supervised as follows:

1. **Physician Assistants (PAs)** - Physician Assistants will:

a. Exercise judgment within their clinical scope of practice, providing that a physician member of the Medical Staff will have ultimate responsibility for their patients' care. Each PA will have one or more designated physician supervisor, either physically present in VANTHCS (or its satellites), immediately available for telephone consultation, or available to be physically present within 15 minutes.

b. Participate in the management of patients under the supervision or direction of one or more physician supervisor(s).

c. Within the limits established by the Medical Staff and consistent with the State Practice Acts and VA regulations, write orders and record reports and progress notes in patient medical records.

d. Be assigned individually to an appropriate clinical service and will carry out their activities subject to service policies and procedures and in conformity with a clinical scope of practice and the applicable provisions of the Medical Staff Bylaws and Rules. Refer to VANTHCS Memorandum No.119-01, "Drug Policy and Procedures" regarding medication usage and orders.

2. Certified Registered Nurse Anesthetists (CRNA's)

a. CRNA's - Exercise judgment within their clinical scope of practice, providing that a physician member of the Medical Staff will have ultimate responsibility for their patients' care.

3. Clinical Pharmacy Specialists (CPS)

a. CPS will operate under the guidelines of the Affiliate Medical Staff definitions, paragraph D of these Bylaws.

VI. MEDICAL RECORDS

A. Basic Administrative Requirements

1. Content - All entries made to the medical record will be intelligible, dated, and authenticated with an electronic signature.

2. Confidentiality - All Medical Staff will abide by VANTHCS Memoranda Nos. 04D-01, "Release of Information" and 00-16, "Privacy Policy" regarding Release of Information and Privacy. HIPAA guidelines will be followed at all times.

3. Clinical encounters are defined by VHA Directive 1082. All encounters requiring clinical notes and encounter forms will be completed within 1 calendar day in accordance with timeframes noted in VHA Policy, State laws, and regulations to ensure patient safety and continuity of care. Exceptions will

include official travel and unanticipated absences (sick leave, emergency leave, etc.). Supervisors may also grant extensions for annual leave and periods affected by CPRS downtimes, as appropriate. Extensions allowing completion of more than 3 calendar days are strongly discouraged from a patient safety and continuity of care perspective.

4. The Computerized Patient Medical Record System (CPRS) is the official medical record. All primary means of documentation is required to be in CPRS.

B. Responsibility of Medical Staff for Authentication

1. Authentication of a medical record entry is the responsibility of the medical provider making the entry and should be done as soon after the preparation or completion of the entry as possible.

2. Residents or other individuals (House Staff) not permitted to provide services independently will have patient History and Physicals and Discharge Summaries countersigned by the responsible supervising attending Medical Staff member. An Attending Admission note, per VHA Handbook 1400.1 Resident Supervision, is also required.

3. Staff physicians will also enter periodic notes in the patient's medical record, or at a minimum, countersign the resident's notes verifying concurrence with diagnoses and management.

4. No Medical Staff member will be required to authenticate entries that are not the staff member's own.

C. Symbols and Abbreviations

1. Symbols and abbreviations may be used in the medical records only when they have been approved by the Health Information Management Committee and have final approval from Clinical Quality Management.

2. Symbols and abbreviations will not be used when documenting in the Discharge Summary final diagnoses, complications or operative procedures on patients released from inpatient and ambulatory/outpatient services.

D. Release of Information (ROI)

1. Information from a medical record will be released to an outside entity only with the signed Release of Information (VA Form 10-5345) of the patient or person authorized to act for the patient.

2. All requests involving release of information will be forwarded to Medical Administration Service (MAS). Oversight is by the Privacy Officer, and all ROI requests must comply with HIPAA guidelines as well as VANTHCS

Memoranda 136-04 and 136-06 as noted above under Basic Administrative Requirements (A.2).

E. Timeframes for Completion of Records

1. Medical Records should be completed in accordance with timeframes noted in VHA Policy, State laws, and regulations.

2. A medical record is considered complete only when it contains:

   a. Authenticated History and Physical Examination
   b. All Authenticated Operative Reports from that admission
   c. Authenticated Doctor's Orders
   d. Authenticated Discharge Summary
   e. Coding and entering into Patient Treatment File (PTF)

3. Documentation of emergency care should be completed by the end ofthat shift and signed off to ensure it is visible to other caretakers.

F. Basic Requirements for Content of the Medical Record

1. Patient identification (name, address, SSN, DOB, telephone contact nextof kin)

2. Medical History and Physical Examination, including history and details of present illness/injury

3. Observations, including results of therapy, documented in Progress Notes

4. Diagnostic and therapeutic orders

5. Reports of procedures, tests, and their results

6. Progress notes by physicians, nurses, and ancillary care staff, as indicated

7. Consultation reports

8. Informed consent before procedures or treatments are undertaken and, ifnot obtained, documentation of the reason

9. Documented Universal Protocol ("Time Out") before procedures are started

10. Documentation of patient education

11. Allergies

12. Advance Directive/DNR

G. Inpatient Medical Records

1. History and Physical Examination (H&P)

   a. Per 42 CFR §482.22, a medical history and physical (H&P) examination will be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The practitioner will document in a progress note any interim changes to the H&P within 24 hours of admission, when using a previously recorded H&P, as described above. The initial and updated H&Ps including any changes in the patient's condition, must be completed and documented by a physician, a maxillofacial surgeon, or other qualified licensed individual in accordance with VHA regulations, VANTHCS policy, and state law. H&Ps entered by a resident physician will be cosigned by an attending medical staff member in accordance with timeframes noted in VHA Policy, State laws, and regulations.

   b. For patients admitted primarily for dental diagnoses and treatment, a history and clinical evaluation of the dental/oral problem will be completed by the admitting dentist.

   c. If a patient is readmitted within 30 days following the date of discharge for the same or a related condition, an Interval History and Physical Examination reflecting any subsequent changes may be used in the medical record. When used, an Interval H&P will be entered on a Progress Note and contain the following:

      1) A statement that the previous H&P examination has been reviewed and/or

      2) A statement about pertinent additions to the history and/or subsequent changes in the physical findings, or a statement indicating there is no change noted in the review of the previous H&P examination.

   d. H&P's written by PAs and APRNs will not require co-signature by the attending physician unless otherwise specified in the individual's scope of practice.

2. Initial Assessment

   a. The medical records of all patients will contain a documented statement of the treatment plan, which may appear at the conclusion of the H&P. Medication Reconciliation will be accomplished through comparing the patient's preadmission medication ("Home List") with the medications which will be provided to the patient during hospitalization. See VANTHCS Memorandum No. 11CHIO-01, "Medication Reconciliation".

b. This statement will be based upon the outcome of the initial assessmentof the patient and will include those diagnostic/therapeutic procedures and/or activities planned to restore the patient to a maximum level of health and social function, and, as appropriate, employment.

3. Progress Notes

As required by TJC standards, patient records will contain the following, as appropriate, in the Progress Notes:

a. Admission note
b. Inter-service Transfer notes
c. Pre-anesthetic and preoperative notes
d. Operative and/or procedure reports
e. Post-anesthetic and postoperative notes
f. Withholding or withdrawal of life-sustaining procedures orAdvance Directive notes
g. Seclusion and/or restraint notes
h. Discharge and/or patient instruction note
i. Documentation of medication reconciliation
j. A progress note with justification is required for a patient who is granted pass or leave privileges.
k. Specific progress notes will be recorded, as appropriate, to conform with existing directives:

1) Note regarding oral consent for performance of certain procedures
2) Note of medical problems requiring emergency identification
3) Note pertaining to the testamentary capacity of the patient
4) Note documenting verbal informed consent for performance ofdental operations and other procedures
5) Social Work Service closing summary
6) Dental Summary

4. Doctor's Orders

a. All doctor's orders will be timed and in accordance with TJC Standards and VHA regulations.

b. Removal of a patient from suicidal observation will be made only with the approval of a Mental Health staff physician or the ACOS for Mental Health Service.

c. Do Not Resuscitate (DNR) orders will be documented only by a staff physician and may not be entered verbally or by telephone order.

d. If an Advance Directive (AD) is on file in the patient record or electronic record, the physician primarily responsible for the patient will documentthe existence and scope of the AD in the Progress Notes.

e. Access to patient movement functions ("ADT") is restricted to trained users. If, after exploring any potential alternatives, it is decided that a patient movement order needs to be deleted, the attending provider will review all clinical orders prior to the deletion and ensure that all pertinent orders are subsequently restored/reinstated.

5. Informed Consent

a. Medical records must document the performance of treatments and procedures requiring informed consent, as outlined in VANTHCS Memorandum No. 11-04 "Informed Consent for Clinical Treatment and Procedures".

b. Treatments or procedures that involve experimental protocols, the use of investigational drugs or research have special informed consent requirements; see M-3, Part I, Chapter 9.

6. Discharge Summary

a. A Discharge Summary is prepared for all releases from hospital, domiciliary and transitional care, including deaths and transfers to other levels of care such as VA Domiciliary care, VA CLC, other VA medical centers, and non-VA medical centers. See VANTHCS Memorandum 139-02 "Discharge Policy" for details.

b. The discharge summary will be completed (signed) and available for review in CPRS in accordance with timeframes noted in VHA Policy, State laws, and regulations and will include at least:

1) Reason for admission
2) Findings
3) Treatment given
4) Procedures performed
5) Condition on discharge
6) Pertinent discharge instructions
7) A reconciled list of medications which is comprised from a review of the admission medications and the discharge medications. A copy of this list will be provided to the patient and will be available to the after-hospitalization provider through CPRS or by hard copy. Please refer to VANTHCS Memorandum No. 11CHIO-01 "Medication Reconciliation" for the full guidelines on medication reconciliation.
8) Arrangements for post-hospital care

c. Responsibility for the preparation of the discharge summary and its content rests with the member of the Medical Staff having primary care responsibility for the patient. Where primary care is being rendered by House Staff, the attending physician will assure appropriate and timely

preparation of the summary and authenticate it with co-signature in CPRS.

d. No set standard of length of a discharge summary is prescribed, but the responsible Medical Staff member should exercise judgment and present essential pertinent information as clearly and concisely as possible.

e. Dentist members of the Medical Staff shall prepare and sign a Discharge Summary for those patients admitted primarily for dental diagnoses and treatment.

f. At the time of completing 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 physician or dentist shall complete his/her portion of the record in accordance with timeframes noted in VHA Policy, State laws, and regulations, including authentication.

H. Outpatient Medical Records

1. Patient Problem List

   a. The record of each patient on ambulatory and/or outpatient status who has three or more visits within a six-month period at a VA facility will include a list of known significant diagnoses, conditions, procedures, drug allergies and current medications.

   b. Entries other than diagnoses, if significant, for the information of the health care team, may be recorded on the Problem List.

   c. The Problem List will be initiated by the third outpatient and/or ambulatory care visit to the health care provider and updated as necessary upon subsequent outpatient and/or ambulatory care visits.

   d. Attempted suicide will be documented on the Problem List.

2. History and Physical Examination

   a. When a patient is admitted to VA care at an ambulatory and/or outpatient care level, a relevant history of the illness or injury and physical findings will be documented in the patient record.

   b. When a patient is scheduled for sedation/analgesia, they will undergo a focused physical examination by the privileged sedation provider as outlined in VANTHCS Memorandum 112A-02, "Administration of Moderate Sedation and Analgesia (Conscious Sedation)".

   c. Per VANTHCS Memorandum 112-01, "Pre-Surgical Screen (ABO/RH and Antibody Screen) on Outpatients Scheduled for Surgical Procedures", a

pre-surgical screen should be ordered and collected during the pre-operative evaluation period to ensure that outpatients scheduled for surgical procedures with a potential need for transfusion have a completed blood type and antibody screen in VANTHCS' blood bank database before the day of admission

d. Pre-procedure History and Physical (H&P)

b. When a patient is placed in an outpatient program following an episode of inpatient care, the initial note will reflect an assessment or statement ofthe condition(s) for which that care is being provided.

c. Special protocols as prescribed into current directives will be followed for certain other patients such as OEF-OIF-OND veterans, Gulf War veterans, former POWs, and those who claim exposure to nuclear tests, ionizing radiation, Agent Orange, or environmental contaminants.

d. The results of examinations required by protocol will be in CPRS. These records may include Compensation and Pension Examination records in cases in which the veteran is not now and has not been a patient.

e. H&P's written by PAs and APRNs will not require co-signature by the attending physician, unless otherwise specified in the individual's scope of practice.

3. Treatment Plan

a. A statement of the planned treatment will be documented for all other ambulatory/outpatients following the initial assessment and whenevera change in treatment is indicated.

b. A treatment plan will be documented for each Home Based PrimaryCare (HBPC) patient and Spinal Cord Injury home care patient which will describe those services and activities required and the treatment objectives.

c. Medication Reconciliation – As noted in the section above on Inpatient Medical Records (section 6. b., VANTHCS Memorandum No. 11CHIO-01 "Medication Reconciliation provides guidance on Medication Reconciliation procedures.

4. Progress Notes – General

a. A pertinent progress note will document each ambulatory/outpatientcare visit. The quality of the notes will be similar to that of inpatient notes.

b. Progress Notes should contain sufficient information to:

1. Identify the patient
2. Support the diagnosis
3. Justify the treatment
4. Document the course and results
5. Facilitate continuity of care

c. Notations concerning broken appointments or termination of treatment will be made in the Progress Notes.

d. Vital signs will be documented at the time of the H&P as well as during interval outpatient visits.

5. Progress Notes – Mental Health – Outpatient with more than two visits a week

a. Each visit will be documented in CPRS
b. Any significant change noted in the patient's condition during the visit will be documented with a brief note.
c. A summary of the patient's participation will be documented monthly.

6. Progress Notes – Ambulatory Surgery – The medical record thoroughly documents operative or other procedures and the use of anesthesia or moderate sedation, and includes documentation of Universal Protocol.

7. Doctor's Orders – Doctor's orders will be entered into CPRS. To facilitate appointment scheduling and assure pre-appointment readiness, laboratory studies requested within the context of a Return to Clinic Order, which has been authenticated by a Medical Staff member, may be replicated by Medical Support Assistants into individual laboratory orders, to exactly match the first record of each laboratory request in the Return to Clinic Order, utilizing the "Signature on Chart" option. The Medical Staff member remains ultimately responsible for all laboratory orders, including any that cannot be replicated as requested in the Return to Clinic Order.

8. Informed Consent – Documentation of informed consent will be made a part of the ambulatory/outpatient care record prior to surgery or any other procedure requiring informed consent. See VANTHCS Memorandum No. 11-04, "Informed Consent for Clinical Treatments and Procedures".

I. Emergency Care Records

1. The qualitative standards for recording data on periods of emergency care will be equivalent to those for inpatient hospital care. Every precaution will be taken to have a complete record that is adequate for medical/legal purposes.

2. When emergent, urgent, or immediate care is provided, documentation will include:

a. Time and means of arrival

b. Brief H&P
c. Diagnostic testing performed
d. Treatment rendered
e. Diagnosis
f. Final disposition
g. Condition at discharge
h. Medication Reconciliation
i. Instructions for follow-up care
j. Notation if patient left against medical advice

3. Urgent or emergent care rendered for humanitarian reasons to a person who is not admitted and/or who is not eligible for care at VANTHCS will be documented in a patient record. Urgent or emergent care information will be incorporated into an existing patient record whenever one exists.

J. Operating Room Records

1. Pre-Anesthetic Risk Assessment

a. A Staff Anesthesiologist or member of the anesthesia care team (Staff Anesthesiologist and Nurse Anesthetist, Physician Assistant, or Anesthesia Resident) will perform a Pre-Anesthetic Risk Assessment on patients scheduled to have any procedure requiring anesthesia service. Information obtained will be recorded electronically or on a pre-anesthesia evaluation chart using VA Form 10-585 (549) "DVAMC Anesthesia Record" (hardcopy). This information will be collected before the procedure

b. Patient name, complete identification number, age, gender, height, weight, allergies, baseline vital signs, past medical history, physical examinations, current medications, past surgical interventions, and complications of previous anesthetic experiences should be recorded. Information required to complement this evaluation includes results of any preoperative workup (laboratory, diagnostic imaging, EKG, other pertinent invasive or non-invasive studies) and consultations by other services.

c. A Staff Anesthesiologist will determine the necessary pre-operative tests required to adequately assess the risk of a patient's undergoing anesthesia for the procedure. Appropriate medical consultation will be sought for individual patients when indicated. A risk classification status will be designated according to American Society of Anesthesiologists (ASA) Guidelines.

d. Patients or their representatives will be informed about alternatives to anesthesia and anesthetic preoperative risks except in extraordinary situations in which the patient requires emergency surgery, is incapable of giving informed consent and a representative cannot be reached. A description of this discussion will be documented in the preoperative

evaluation form.

2. Risk Assessment on the Day of Procedure

   A Staff Anesthesiologist will also perform a risk assessment on the day of the procedure immediately before induction of anesthesia. It is the responsibility of this physician to re-evaluate and confirm the previously gathered information immediately prior to rendering anesthesia service and establish the patient's readiness for the procedure. As part of the anesthesia care team, nurse anesthetists and residents are responsible for assessing and recommending an anesthetic plan for cases in which they are involved, but it is the responsibility of the Staff Anesthesiologist to determine the final anesthetic plan. This assessment will be documented electronically in a progress note in the patient's medical record.

3. Intra-operative Anesthesia Record

   a. The Anesthesia care team will keep a record of the patient's vital signs, ASA status, anesthetic technique, special monitoring devices, medications used, patient positioning, intra-operative events and time keeping while providing anesthesia service. This will be in concordance with the Standards for Basic Anesthesia Monitoring established by the American Society of Anesthesiologists (ASA).

   b. The Staff Anesthesiologist of record will determine the final anesthetic plan including the need for invasive monitoring for each individual.

   c. A computer-generated electronic Anesthesia Record form will be documented in CPRS.

4. Operative and Post-operative Surgical Records - General

   a. A pre-operative diagnosis is recorded before surgery by the licensed independent practitioner responsible for the patient.

   b. Operative Reports will be 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 will include:

      1) Names of the supervising practitioner, primary surgeon and assistants; and the presence and/or involvement of the supervising practitioner
      2) Indication for the procedure
      3) Operative findings
      4) Technical procedures used
      5) Specimens removed
      6) Post-operative diagnosis

c. When the detailed Operative Report is not placed into the medical record immediately following surgery, a Brief Operative Report is entered immediately as a Progress Note into CPRS.

d. Post-operative documentation records will include:

1) Patient's vital signs and level of consciousness
2) Medications (including intravenous fluids)
3) Blood and blood components administered
4) Any unusual events or postoperative complications
5) Management of such events

e. Post-operative documentation must record patient discharge from the Post-Anesthesia Care Unit by the responsible licensed independent practitioner and document compliance with discharge criteria.

f. Post-operative documentation records the name of the licensed independent practitioner responsible for discharge.

5. Operative/Procedure Reports on Procedures Performed Outside the Operating Room (OR).

a. Electronic documentation of all diagnostic and therapeutic procedures not performed in a main OR or a specialized operating/treatment room will be entered in the patient's CPRS Progress Notes. This documentation signed and authenticated by the responsible Medical Staff member, will consist of the following:

1) The name of the procedure and the date it was performed
2) The name(s) and title(s) of those performing the procedure
3) The indications for the procedure
4) Relevant details concerning the performance of the procedure, including a description of the specimens removed
5) A list of the major findings and conclusions
6) A discussion of complications, including plans for following up on the complications
7) The condition of the patient at the conclusion of the procedure

6. Post-Anesthesia Care Unit (PACU) Admission and Progress Notes

a) Patient will be admitted to the PACU in order to monitor recovery from anesthesia. Guidelines outlined in PACU policies and procedures manual must be followed.

b) The anesthesia care team will give a report to the receiving care giver that includes, but is not limited to, past medical history, allergies, intra-operative information, current status and post-operative instruction. A note describing the occurrence and content of this dialogue must be

documented in a CPRS Progress Note or in the anesthesia record.

c) Notes documenting the patient's course in PACU will be entered into CPRS.

d) Patients receiving Monitored Anesthesia Care (MAC) or intravenous sedation analgesia ("Moderate Sedation") may bypass PACU and go directly to second stage recovery or to the unit if the Staff Anesthesiologist considers it appropriate. A note will document this decision in the patient's CPRS record.

7. PACU Discharge Note

After a patient recovers from anesthesia, a Staff Anesthesiologist will assess the patient's recovery status prior to discharge from PACU. Alternatively, the patient may be discharged from PACU, once he/she satisfies the discharge criteria outlined in the "Post Anesthesia Care Unit Policy and Procedure Manual PACU Discharge Criteria", if the Staff Anesthesiologist considers it appropriate. A report on the patient's hemodynamic status, level of consciousness, and recovery status from a regional anesthetic will be documented electronically or on a pre-anesthesia evaluation chart using VA Form 10-585 (549) "DVAMC Anesthesia Record" (hardcopy) prior to discharge from PACU. A review of the PACU nurse's notes including vital signs, medications given, and fluid management will be used to assess the patient prior to discharge.

8. Post-Anesthetic Progress Note

a) Inpatients will be evaluated by a member of the Anesthesiology and Pain Management Service to determine the presence or absence of anesthesia-related problems or complications in accordance with timeframes noted in VHA Policy, State laws, and regulations. Patient status will be documented through an electronic note or a written note in the patient's chart using VA Form 10-585 (549) "DVAMC Anesthesia Record" (hardcopy) if electronic means are unavailable.

b) A patient discharged home after a same-day procedure will be called by telephone at home by Day Surgery Unit personnel to inquire about patient status and complications as per their unit guidelines. Evidence of anesthesia-related complications obtained via the above-mentioned communication will be communicated immediately by a member of the Day Surgery Unit to the Anesthesiology and Pain Management Service.

c. All serious complications will be promptly reported to Patient Safety for further investigation.

9. Intravenous Sedation and Analgesia: Outside the main Operating Room, patients receiving moderate sedation analgesia (Moderate Sedation) by non-

anesthesia providers, will be monitored and followed per the guidelines established in VANTHCS Memorandum No. 112A-02 "Administration of Moderate Sedation/Analgesia (Conscious Sedation)". In addition, non-anesthesia providers must hold privileges for Moderate Sedation.

10. VANTHCS Memorandum No. 112-06, "Organ Donation and Donation of Body For Science" outlines policies and procedures governing the removal of cadaveric organs or tissue for donation.

K. Extended Care Medical Records

1. Patients transferred from acute inpatient care to Extended Care require a completed Discharge Summary prior to their admission to Extended Care.

2. Admission Note

   a) An admission note will be recorded in CPRS by the attending physician in accordance with timeframes noted in VHA Policy, State laws, and regulations. This note will contain an assessment of the factors responsible for admission to Extended Care, including the patient's medical, functional, and mental status.

   b) A History and Physical Examination (H & P) completed and entered into the medical record in accordance with timeframes noted in VHA Policy, State laws, and regulations, will meet the requirements for an admission note.

   c) The existence and scope of an Advance Directive on the patient will be documented in CPRS upon admission.

3. H&P

   a) A H&P will be completed by the attending physician in accordance with timeframes noted in VHA Policy, State laws, and regulations. This H & P will contain an accounting of the patient's current medical illnesses, medications, allergies, immunization status, social history, systems review, physical findings, and mental status. An initial impression and plan of care will be included. Also, prognosis and potential for rehabilitation will be stated if clinically appropriate. The existence and scope of an Advance Directive on the patient will be documented in CPRS upon admission.

   b) An Interval H & P may be utilized if a patient is readmitted to Extended Care in accordance with timeframes noted in VHA Policy, State laws, and regulations.

   c) Patients residing in Extended Care for more than one year will receive an annual physical examination, including assessment of current mental and physical status.

d) H&P's written by PAs and APRNs will not require co-signature by the attending physician unless otherwise specified in the individual's scope of practice.

4. Plan of Care

a) An interdisciplinary Plan of Care is developed for each patient admitted in accordance with timeframes noted in VHA Policy, State laws, and regulations.

b) Discharge planning will be included in the interdisciplinary Plan of Care.

5. Progress Notes

a) Progress notes are entered into CPRS for Extended Care patients to document changes in the patient's condition as they occur and the patient's response to prescribed interventions. These will be entered in accordance with timeframes noted in VHA Policy, State laws, and regulations or by the patient's changing condition.

b) Progress notes written by subspecialty services for Extended Care inpatients will be entered into CPRS.

6. Doctor's Orders

a) Orders will be entered electronically into CPRS and include the requirements of acute inpatient care, including date, time and signature of the provider writing the order.

b) Orders written by PAs and APNs will not require co-signature by the attending physician, unless otherwise specified in the individual's scope of practice.

7. Discharge Summary

A Discharge Summary is required on all patients discharged from Extended Care. It will be completed in accordance with timeframes noted in VHA Policy, State laws, and regulations.

VII. INFECTION PREVENTION AND CONTROL

A. **Infection Prevention and Control Manual** – VANTHCS Memorandum 11IPC-01 "Infection Prevention and Control (IPC) Program" establishes infection control policies (collectively referred to as the infection control manual) to prevent the spread of infection to patients, personnel, and visitors. Infection Prevention and Control standards specific to each service are written in each service's respective standard operating procedures (SOP). A manual is located in every service and

every patient care area and on the VANTHCS Intranet site. Refer to Infection Prevention and Control Manual for details.

B. **Authority for Infection Prevention and Control** - The Chairperson, Infection Control Committee, or delegated alternate, has the authority to determine what measures are necessary to prevent or control transmission of infections and to institute any appropriate control measures with approval by the Chief of Staff. These measures may include, but are not limited to, restricting unit or hospital admissions, cohorting or isolating patients, removing employees from patient contact, and obtaining appropriate cultures or other tests from patients, staff, or the health care environment.

VIII. DISASTER PREPAREDNESS AND OPERATIONS

A. Emergency Operations Plan

1. The Emergency Operations Plan is detailed on the VANTHCS Intranet site and provides a comprehensive guide to responding to emergency situations that may occur at or involving VANTHCS. It provides an outline for the care of mass casualties. It is to be implemented in the event of a variety of emergencies including fire, severe weather, explosions, utility outages, threats to cause harm or destruction, and/or other disasters involving this health care system. The plan may also be implemented during a community disaster and may require the treatment of civilian casualties. A hard copy of the plan can be found in every Service Chief's office as well as other areas throughout VANTHCS.

2. National Disaster Medical System (NDMS). The health care system's mission assignment is to serve as a Primary Receiving Center (PRC) and a Federal Coordinating Center (FCC) under the NDMS. The NDMS Program is activated under the Federal Response Plan during presidentially declared disasters.

3. Privileging of providers during an emergency is covered in the VANTHCS Emergency Operations Plan (EOP) as well as Article 5 Section 9 of the Bylaws.

B. VA/DOD Contingency Plan

1. General Provisions

   The health care system VA/DOD Contingency Plan has been prepared to comply with Department of Veterans Affairs (VA) and Veterans Health Administration (VHA) mission tasking under Public Law 97-174. The health care system's mission assignment is to serve as PRC, and a FCC under the NDMS.

2. Purpose

a) The Department of Veterans Affairs and Department of Defense (VA/DoD) Contingency Plan defines the role of the health care system with policies and procedures relative to VA/DoD joint contingency planning, implementation, and support.

b) Public Law 97-174 (38 U.S.C. 5011.A), the Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act, mandates that VA support the military health caresystem during and immediately following a period of war or national emergency declared by the President or Congress. This emergency medical preparedness program requires VA health care systems to develop contingency plans to care for the large number of casualties expected in such situations.

3. Scope - This plan is applicable to all employees of VANTHCS. It is a component of the Emergency Operations Plan, supplementing VANTHCS Emergency Preparedness Plan, which may serve as annexes to theVA/DoD Plan where applicable.

4. Implementation - Upon notification by the Secretary of Veterans Affairs, the Under Secretary for Health of the Veterans Health Administration (VHA) will activate the VA component of Contingency Hospital System (CHS). The Heart of Texas Veterans Health Care Network Director, VISN 17, will notify the VANTHCS Director who will initiate the health care system's emergency notification or "Cascade" system, as necessary. Cascade recalls ensure that appropriate personnel are available in the health care system to provide services consistent with the General Mission Statement Service Plan Section of Emergency Operations Plan).

5. Priority of Care - DOD patients will receive priority care over all VA beneficiaries except service-connected (SC) veterans, or non-service (NSC) veterans with a life-threatening emergency. NSC inpatients who may be discharged without a significant compromise of their health will be released from the health care system; others may be referred to secondary support centers or community hospitals, as appropriate.

6. Outplacement of NSC Patients - Under Public Law 97-174, service-connected veterans retain the highest priority for care in VHA. In a VA/DoD contingency, active duty military personnel receive a higher priority than NSC veterans. Thus, in order to free up beds to meet our mission goal, NSC veterans may be discharged or transferred to other VA or community health care facilities. The attending physician will make the determination as to whether a NSC veteran can be discharged without a significant compromise to his/her health. If it is medically compromising to discharge, but movement is feasible, the patient may be transferred to an assigned VA secondary support center or to a community hospital. This transfer will be made in accordance with the procedure outlined in VANTHCS Memorandum No. 136-

07 "Inter-Facility Transfer Policy".

NOTE: VA WILL MAINTAIN RESPONSIBILITY FOR CONTINUITY OF CARE FOR PATIENTS WHO ARE DISCHARGED OR TRANSFERRED

7. Responsibilities - Medical Staff member responsibilities during the implementation of the VA/DoD Contingency Plan are outlined in the individual service component of the Emergency Operations Plan.

IX. IMPAIRED PROFESSIONAL PROGRAM

A. The Health Standards Board (HSB) is established for the purpose of determining whether physicians, dentists, podiatrists, optometrists, chiropractors, nurses, physician assistants, expanded-function dental auxiliaries, and residents and interns who are subject to the provisions of VA Handbook 5005, Part II, Chapter 3 are physically fit for appointment or retention in VA employment. For details, see VANTHCS Memorandum No. 11-08, "Physical Standards Board".

B. Those cases of questionable nature that have not been resolved, or have been resolved unfavorably by consultation, will be referred to the HSB fordetermination of physical or mental fitness. The Board will decide whether the individual examined can perform the required service satisfactorily without hazard to VA beneficiaries, employees, or self. The findings of the HSB will be submitted through the Chief of Staff to VANTHCS Director for final disposition.

C. VANTHCS contends that behavioral problems that affect work performance and/or attendance are legitimate concerns of management. Such problems take the form of alcoholism, drug abuse, emotional stress, and other debilitating experiences. VANTHCS considers such problems as health related and has established a procedure for providing employee assistance in such areas. Further details on this program are discussed in VANTHCS Memorandum No. 11-08, "Physical Standards Board".

D. Behavior or behaviors by medical staff members that undermine a culture of safety is considered an impairment to provision of safe, high quality patient care. Therefore, Medical Staff members who are consistently disruptive, hostile, or threatening will be referred for pertinent behavior management training such as anger management, interpersonal skills training, and/or team building. If this behavior continues after appropriate referral, the Service Chief will make a recommendation to the ECMS regarding retention of the individual as a member of the Medical Staff.

X. PEER REVIEW

VHA Directive 2008-004 describes the purpose of Peer Review. As stated in the Directive, "the authority for Protected Peer Review is found in Title 38 United States Code (U.S.C. 5705, entitled Confidentiality of Medical Quality-Assurance Records, and its implementing regulations. Only documents designated in advance as being

developed consistent with 38 U.S.C. 5705 are confidential". VANTHCS Memorandum 00QSV-07 outlines the procedures locally.

The Peer Review Committee, which reports regularly to the ECMS, will notify the Director immediately upon determining if the matter under review raises concerns about the possibility of substandard care, omission of care or negligence. The findings may be used as triggers to conduct a Focused Professional Practice Evaluation (i.e. management review) for non-protected purposes, such as determining the need for an adverse privileging action. Please refer to VANTHCS Memorandum No 11-03 "Focused Professional Practice Evaluation" for the full process.

The processes of Quality Improvement are closely linked to the Peer Review principles. All members of the Medical Staff will participate in Quality Improvement relating to the service of which they are a member. On occasion, Peer Review may include review of cases outside of VANTHCS but which are assigned to us by the Office of Medical-Legal Affairs (OMLA) the Office of General Counsel (OGC), or from VA's within or outside our VISN via the VISN 17 Chief Medical Officer.