BYLAWS AND RULES OF THE MEDICAL STAFF
OF
VETERANS HEALTH ADMINISTRATION (VHA)

SOUTHEAST LOUISIANA VETERANS HEALTH CARE SYSTEM (SLVHCS)

NEW ORLEANS, LOUISIANA

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PREAMBLE *

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

Southeast Louisiana Veterans Health Care System consists of an outpatient medical center in New Orleans and 7 community based outpatient clinics (CBOC) in Louisiana: Slidell, Hammond, Bogalusa, Baton Rouge, Houma, St John, and Franklin. In addition, there is an ambulatory procedural unit in New Orleans. SLVHCS provides primary care, specialty services, mental health and home-based services to veterans across 23 parishes in southeast Louisiana, primarily to an adult and geriatric veteran population. The mission of SLVHCS is fourfold: clinical care, education, research, and backup to the Department of Defense and community in a national emergency.

NOTE: SLVHCS (at the time of the writing of these revised Bylaws) is in the process of activating a new tertiary care VA Medical Center, scheduled to care for its first patients in late 2016. The new medical center is currently in its last phase of construction in New Orleans. Thus, some of the modifications in this version of the Bylaws will not become relevant until the inpatient facility opens.

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

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

1. Affiliation (Academic) Partnership Council (formerly known as the Deans Committee): established by a formal memorandum of affiliation between this Health Care System and Tulane University School of Medicine, the Louisiana State University School of Medicine, and the Louisiana State University School of Dentistry composed of deans and senior faculty members of the University's medical and dental schools, representatives of the medical/dental staff of the Health Care

System, and others, as per the Council charter. VHA Handbook 1400.3 September 24, 2002

2. Advanced Practice Professionals: "Advanced Practice Professionals" (a term used by the VHA), are defined as health care professionals who, most often, function within a Scope of Practice but may practice independently on defined clinical privileges as defined in a facility's Bylaws. Advanced Practice Professionals are defined in these Bylaws as physician assistants (PA) and advanced practice registered nurses (APRNs), including, certified registered nurse practitioners (CRNPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). **NOTE:** Advanced Practice Professionals are not considered licensed independent practitioners (LIP) in the state of LA. Advanced Practice Professionals may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations, under the supervision of or in collaboration with a credentialed and privileged physician as required by state regulations. Advanced Practice Professionals may also initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations. Advanced Practice Professionals may be granted admitting privileges in accordance with a scope of practice. APRNs and other health care professionals may be granted defined clinical privileges when allowed by law and the Medical Center (a facility decision). NPs and PAs caring for patients will have access to a physician from whom timely collaboration is expected as well as appropriate documentation in the medical record. Physicians will have sufficient time allocated during the work day for the purpose of NP or PA collaboration (SLVHCS NM 11-39, 2012 Scope of Practice for Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Clinical Pharmacy Specialist, and Certified Registered Nurse Anesthetist).

3. Allied Health Professional: An individual, other than a member of the medical staff, who is permitted by law and by the Health Care System to provide patient care services independently. An allied health professional works in health care teams to by providing a range of diagnostic, technical, therapeutic and direct patient care and support services that are critical to the other health professionals and patients. They include, but are not limited to, audiologists, social workers, and speech pathologists. For simplicity all pronouns in reference to allied health professionals are in the masculine.

4. Appointment: As used in this document, the term Appointment refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, Advance Practice Professionals and/or patient care services at the Medical Center. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff.

5. Associated Health Professional: As used in this document, the term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine. These professionals include, but are not limited to pharmacists, psychologists, podiatrists, and optometrists. Associated Health Professionals function under either defined clinical privileges or a defined scope of practice.

6. Attending physician is defined as a medical staff physician. The term "attending physician" and "staff physician" are used interchangeably. When residents, interns, or fellows are involved, the Attending physician is responsible for all care in which interns, residents, or fellows are involved.

7. Automatic Suspension of Privileges: Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Executive Committee of the Medical Staff (ECMS). Also see "Summary suspension of privileges," #34, below.

8. Chief of Staff: The Chief of Staff is the Chair of the Medical Staff and Chair of the Executive Committee of the Medical Staff (ECMS) and acts as full advisor to the Medical Center Director in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioners, Advanced Practice Professionals, and Associated Health Professionals.

9. Clinical Privileging: The process by which a practitioner, licensed for independent practice (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.), is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure. Clinical privileges must be facility-specific, practitioner-specific, and within available resources. NOTE: There may be practitioners, who by the nature of their positions are not involved in patient care (i.e., researchers, administrative physicians, or VHA Central Office staff). These health care professionals must be credentialed, but may not need to be privileged. (See VHA HANDBOOK 1100.19 October 15, 2012).

10. Clinical Service Chiefs: This group is comprised of the Clinical Service Chiefs of Ambulatory and Primary Care, Anesthesiology, Dental, Dermatology, Emergency Medicine, Geriatrics and Extended Care, Medicine, Mental Health, Neurology, Pathology and Laboratory Medicine, Physical Medicine and Rehabilitation,

Radiology, and Surgery who report directly to the Chief of Staff. They fulfill the responsibilities of a department chairperson.

11. Community Based Outpatient Clinic (CBOC): A health care site (in a fixed location) that is geographically distinct or separate from the parent Medical Center. A CBOC can be a site that is VA-operated and/or contracted. A CBOC must have the necessary professional Medical Staff, access to diagnostic testing and treatment capability, and the referral arrangements needed to ensure continuity of health care for currently and potentially eligible veteran patients. A CBOC must be operated in a manner that provides veterans with consistent, safe, high-quality health care, in accordance with VHA policies and procedures.

12. Community Living Centers (CLC) Program (formerly, VA Nursing Home Care Units): The SLVHCS's CLC provides care to eligible veterans with sufficient functional impairment to require the level of service and skill available in the CLC. Veterans with chronic stable conditions including dementia, those requiring rehabilitation or short term specialized services such as respite or intravenous therapy, or those who need hospice or palliative care can be served in the CLC.

13. Credentialing refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, registration, certification, required education, relevant training and experience, and current competence. NOTE: Practitioners who are not directly involved in patient care (i.e., researchers or administrative personnel), but by the nature of their position, have the potential to assume patient care-related duties, or oversee the quality or safety of the patient care delivered, must be credentialed. The VHA expanded the credentialing process to all licensed, registered, and certified health care professionals as described in VHA Directive 2012-030, Credentialing of Health Care Professionals. See Attachment B for a list of occupations covered by credentialing and VHA Handbook 1100.19, October 2012. Also VHA Office of Quality, Safety & Value Medical Staff Affairs (Credentialing &Privileging) at http://vaww.oqsv.med.va.gov/Default.aspx > Safety and Risk Awareness (10A4E) > Medical Staff Affairs.

14. Deputy Director: The Deputy Director fulfills the responsibilities of the Medical Center Director as defined in these Bylaws when serving in the capacity of Acting Medical Center Director.

15. Executive Committee of the Medical Staff (ECMS): This Committee serves and acts for the Medical Staff in intervals between Medical Staff meetings. This board is composed of professional service chiefs and "at large" members of the Medical Staff, appointed by the Medical Center Director, with the Chief of Staff as chairperson.

16. Governing Body: The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for Veteran Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes

of local Medical Center management and planning, it refers to the Medical Center Director. The Medical Center Director is responsible for the oversight and delivery of health care by all employees and specifically including the Medical Staff credentialed and privileged by the relevant administrative offices and Medical Center approved processes.

17. Licensed Independent Practitioner (also known as independent practitioner): The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the facility to provide patient care services independently, i.e., without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges. Only LIPs may be granted clinical privileges. In this organization, LIPs include (but are not limited to) physicians, dentists, podiatrists, licensed psychologists and optometrists, audiologists, and social workers. It may also include individuals who can practice independently, who meet this criterion for independent practice.

18. Medical Center Director (or Facility Director): The Medical Center Director is appointed by the Governing Body to act as its agent in the overall management of the Medical Center. The Medical Center Director is provided counsel by the Chief of Staff (COS), the Deputy Director, the Associate Director, the Associate Director for Patient Care Services (ADPCS), and the Executive Committee of the Medical Staff (ECMS)

19. Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the Medical Staff process that are subject to the Medical Staff Bylaws. The Medical Staff includes both members of the organized Medical Staff and non-members of the organized Medical Staff who provide health care services.

20. Nurse Executive of Patient care services/Nurse Executive: The Nurse Executive is a registered nurse who is responsible for the full-time, direct supervision of nursing services and who meets licensing requirements as defined by Title 38. S/he is the Chairperson of the Nurse Executive Counsel (NEC) and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant advanced practice professional and certain associated health staff and in ensuring the ongoing education of the nursing staff.

21. Organized Medical Staff: The body of Licensed Independent Practitioners who are professionally competent physicians, licensed psychologists, optometrists, podiatrists and dentists who continuously meet the qualifications, standards, and requirements of VHA, this Medical Center, and these Bylaws, and are eligible to vote as Medical Staff members. These individuals 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.

22. Outpatient Clinic: An outpatient clinic is a healthcare site whose location is located at the medical facility and oversight is provided by the medical facility.

23. 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 evaluating current competence.

24. Practitioner: Any physician with an unlimited license, appropriately licensed dentist, or other appropriately licensed individual who provides patient care services independently; that is, without supervision.

25. 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.

26. Privileging. See Clinical Privileging above.

27. Proctoring: Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may be a reduction of privileges.

28. Professional Standards Board (PSB): The Professional Standards Board handles credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matter to the Executive Committee of the Medical Staff as defined in these Bylaws. This board also may act on matters involving Allied Health and Advanced Practice Professionals such as granting prescriptive authority, scope of practice, and appointment. Some professional standards boards (e.g. Nursing, etc.) are responsible for advancement and other issues related to their respective professions.

29. Residents & Chief Residents: The term 'resident' refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties such as internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), dentistry, podiatry, or optometry, regardless of training level, and who participates in patient care under the direction of supervising Practitioners (synonymous with Attending Physician). The term "board eligible" refers to a resident who has successfully completed residency training for initial Board certification in a specialty or subspecialty. The term "fellow" refers to a resident in an accredited subspecialty training program (i.e., cardiology). Residents are not considered members of the Medical Staff due to their training status, but they do participate in patient care under

the direction of the Medical Staff members of the pertinent profession who have clinical privileges in the Health Care System.

a. Chief Resident – In Training: Chief residents who are currently enrolled in an accredited residency training program, but who have not completed the full academic program leading to board eligibility. These chief residents are not independent and cannot be privileged to work in the discipline for which they are being trained.

b. Chief Resident – Post-Training: Chief residents, who have successfully completed an accredited residency program, but engage in an additional year of training and responsibility. These Chief residents are board-eligible or board-certified and are able to be privileged in the discipline of their completed specialty-training program. These chief residents can be appointed as licensed independent practitioners.

30. Rules: Refers to the specific rules set forth that govern the Medical Staff of the Medical Center. 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 Medical Center Director.

31. Service: Equivalent to the Joint Commission on the Accreditation of Healthcare Organizations (THE JOINT COMMISSION) use of the term department.

32. Service Chief (known as Chief), Associates Chiefs of Staff and Section Chiefs: a Service Chief is the lead physician of a SLVHCS clinical service (Ambulatory and Primary Care, Anesthesiology, Dental, Dermatology, Emergency Medicine, Geriatrics and Extended Care, Medicine, Mental Health, Neurology, Pathology and Laboratory Medicine, Physical Medicine and Rehabilitation, Radiology, Surgery). The Service Chief is responsible for all the providers assigned to the clinical Service and to the clinical care provided by the clinical service. The Section Chief supervises the providers within a program of the Service (i.e., cardiology Section within Medicine Service). The Associate Chiefs of Staff (ACOS) lead overarching programs at the SLVHCS and include, but are not limited to the ACOS-Ambulatory and Primary Care, ACOS-Research and Development, ACOS-Education and ACOS-Clinical Operations, ACOS – Clinical Informatics. Additional ACOS positions can be created with the concurrence of the Medical Center Director.

33. Summary Suspension of Privileges: The Medical Center Director has the authority, whenever immediate action must be taken in the best interest of and to protect patient care, to summarily suspend, for cause, all or a portion of a Practitioner's clinical privileges. Such suspension shall become effective immediately upon imposition by the Medical Center Director. Also see "automatic" suspension of privileges, above.

34. 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 are delivered at the site of the patient by a licensed independent health care provider.

35. 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.

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

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana.

ARTICLE II. PURPOSE

The purposes of the Medical Staff shall be to:

1. Ensure that patients receive safe, efficient, timely, and appropriate care across the entire care continuum that is subject to continuous quality improvement practices and that all patients being treated for the same health problem or with the same methods and procedures receive the same level and quality of care.

2. Primary care programs will ensure continuity of care and minimize institutional care.

3. Assure that palliative care programs provide symptom management and a full spectrum of end-of-life resources as well as build an infrastructure for long-term sustainability.

4. Establish and ensure adherence to ethical standards of professional practice and conduct.

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

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

7. Maintain a high level of professional performance of Practitioners authorized to practice in the Medical Center through continuous quality improvement practices and appropriate delineation of clinical privileges.

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

9. Provide a medical perspective, as appropriate, to issues being considered by the Medical Center Director and Governing Body.

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

11. Provide channels of communication so that medical and administrative matters may be discussed and problems resolved.

12. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, Veterans Health Administration.

13. Provide education and training, in affiliation with established programs, and ensure that educational standards are maintained. Care will be taken to appropriately document supervision of resident physicians and other trainees.

14. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations will be the subject of continuous quality improvement, as defined through organizational policies and procedures.

15. Coordinate and supervise the scope of practice of all Advanced Practice Professionals and appropriate Associated Health Practitioners so that their rights and practice goals are achieved and integrated expeditiously to benefit patient care. Each Advanced Practice Professional and appropriate Associated Health Practitioner should have a scope of practice statement or privileges as well as the means employed to coordinate and supervise their function with the Medical Staff consistent with the Bylaws and as required by state law.

16. Advanced Practice Professionals (NPs and PAs) caring for patients will have access to a medical staff physician from whom timely collaboration is expected. Staff physician involvement in patient care involving a NP or PA, including face-to-face care of the patient or involvement in decision-making without direct patient contact, will be documented in the medical record. Physicians will have sufficient time allocated during the work day by the Service Chief for the purpose of NP or PA collaboration.

17. Provide an appropriate research and educational setting which will maintain scientific standards, lead to continuous advancement in professional knowledge and skills, and which will relate to patient needs, care provided, and the findings of quality care review activities.

18. To institute the framework whereby affiliations with medical or educational institutions are maintained in a manner that is of mutual advantage to the patient care and Medical Staff of each participating institution.

ARTICLE III. MEDICAL STAFF MEMBERSHIP *

Section 3.01 Eligibility for Membership on the Medical Staff *

1. Membership: Membership on the organized **Medical Staff** is a privilege extended only to, and continued for, professionally competent physicians, podiatrists, licensed psychologist, optometrists and dentists who continuously meet the qualifications, standards, and requirements of VHA, this Medical Center, and these Bylaws.

2. Categories of the Medical Staff: Categories of membership will be defined as associate, full-time, part-time, intermittent, without compensation (WOC), consulting, fee basis, or contract.

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

4. Residents shall consist of professionals who may or may not be licensed to practice medicine, dentistry, psychology, podiatry, and optometry, but who are still engaged in a postgraduate training program. Their participation in patient care, education or research shall be under the appropriate supervision of a Medical Staff member who is licensed to practice medicine, dentistry, psychology, podiatry or optometry and who has clinical privileges at the Medical Center. Residents are not eligible for membership on the Medical Staff. They may be permitted to serve on designated Medical Center committees in a non-voting capacity, but shall not be required to attend meetings of the Medical Staff.

Section 3.02
Qualifications for Medical Staff Membership and Clinical Privileges *

1. Criteria for Clinical Privileges: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01

must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial:

a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia as required by VA employment and utilization policies and procedures.

b. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine, Osteopathy, or Dentistry from an approved college or university.

c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training.

d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying.

e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.

f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VI or VII or of these Bylaws for a position for which the Medical Center has a patient care need, and adequate facilities, support services and staff.

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

h. English language proficiency.

i. Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.

j. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver's license or passport).

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 Medical Center and these Bylaws to practice independently. All Practitioners listed below are subject to the Bylaws whether they are granted defined clinical privileges or not.

a. The following Practitioners will be credentialed and privileged to practice independently as part of the organized Medical Staff:

   i) Physicians
   ii) Dentists
   iii) Podiatrists
   iv) Licensed psychologists
   v) Optometrists

b. The following Practitioners will be credentialed and may have a defined scope of practice:

   i) Advanced Practice Nurses (CRNP, CNS, CRNA)
   ii) Clinical Social Workers
   iii) Clinical pharmacy specialists
   iv) Physician Assistants

3. Change in Status: Members of the Medical Staff as well as all Practitioners practicing through privileges or a scope of practice must agree to provide care to patients within the scope of their Delineated Clinical Privileges or Scope of Practice and advise the Medical Center Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, the ability to carry out clinical privileges which are held, and any changes in the status of professional credentials, such as, but not limited to, loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society as soon as able, but no longer than 15 days after notification of the practitioner.

Section 3.03 Code of Conduct

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

2635, not asking for or accepting any gift, tip, entertainment, loan, or favor, or anything of monetary value for oneself or any member of one's family from any person or organization that is seeking or has a business or financial relationship with the VA to avoid the appearance that one's official actions might be influenced by such gifts.

The responsibilities of each VHA healthcare professional in understanding how professional obligations can be compromised by financial conflicts of interest are detailed in VHA Handbook 1004.07, November 24, 2014 Financial Relationships Between VHA Health Care Professionals And Industry.

2. Disruptive Behavior and Inappropriate 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 and collegiality. The Accreditation Council for Graduate Medical Education (ACGME) highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Providers should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care. Conduct that could intimidate others to the extent that could affect or potentially may affect quality and safety will not be tolerated. These behaviors, as determined by the organization, may be verbal or non-verbal, may involve the use of rude and/or disrespectful language, may be threatening, or may involve physical contact.

   Disruptive behavior or Behaviors That Undermine a Culture of Safety: is a style of interaction in the workplace with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that Behavior or Behaviors That Undermine a Culture of Safety is often a marker for concerns that can range from a lack of interpersonal skills to health problems, such as depression or substance abuse. As a result, Behavior or Behaviors That Undermine a Culture of Safety may reach a threshold such that it constitutes grounds for further inquiry by the Executive Committee of the Medical Staff into the potential underlying causes of such behavior. Behavior by a provider that is disruptive will be grounds for disciplinary action, including termination.

   VA distinguishes Behavior or Behaviors That Undermine 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 or Behaviors That Undermine a Culture of Safety on the part of other providers. VA expects its providers to support their hospital, practice, or other healthcare organization in their efforts to identify and manage disruptive behavior by taking a role in this process when appropriate.

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

Section 3.04: Conflict Resolution & Management

For VA 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 manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, April 2010 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. VHA expects VA medical center leadership to 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 expected to advise an appropriate supervisor, Patient Safety Officer, or other individuals at the SLVHCS.

ARTICLE IV: ORGANIZATION OF THE MEDICAL STAFF *

Section 4.01 Leaders *

1. Composition:

   a. Chief of Staff

   b. Associate Chiefs of Staff and clinical Service Chiefs

2. Qualifications: The Chief of Staff, Associate Chiefs of Staff, and clinical Service Chiefs are clinically experienced physicians with experience in administration.

3. 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.

4. Removal (Handbook 5021/14, Employee/Management Relations, 2013): 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.

   The leaders of the Medical Staff will be removed if:

   a. They lose their good standing as Medical Staff members related to issues of professionalism, clinical or technical competence.

   b. They lose their good standing as Chiefs of Services or equivalent positions.

   c. They lose their positions as Associate Chiefs of Staff or Service Chiefs or equivalent positions.

5. Duties:

   a. Chief of Staff serves as Chairperson of the Executive Committee of the Medical Staff (ECMS). This individual is the senior clinical leader at the Medical Center.

   b. Associate Chiefs of Staff and clinical Service Chiefs provide clinical and academic leadership for the areas under their jurisdiction.

Section 4.02 Leadership

The Organized Medical Staff, through its committees and Associate Chiefs of Staff (ACOSs) and Service Chiefs, provides counsel and assistance to the Chief of Staff and Medical Center Director regarding the entire spectrum of patient care and treatment, including end of life care, and services including evaluating and improving the quality and safety of patient care services.

Section 4.03 Clinical Services

1. Characteristics:

a. Clinical Services are organized to provide clinical care and treatment under leadership of a Service Chief.

b. Clinical Services hold service-level meetings every month.

2. Functions:

a. Ensure quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring and evaluation of quality and safety (including access, efficiency, and effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; patient safety and risk management activities; and utilization management.

b. Assist in identification of important aspects of care for the Service, and evaluation of the quality and appropriateness of care. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities.

c. Maintain records of meetings that include reports of conclusions, data, recommendations, responsible person, actions taken, and an evaluation of effectiveness of actions taken. These reports will be forwarded in a timely manner through channels established by the Medical Staff.

d. Develop criteria for recommending clinical privileges for members of the Service and ensure that ongoing professional practice evaluation (OPPE) is performed and results are utilized at the time of re-privileging.

e. Define and/or develop clinical privilege statements including levels (or categories) of care that include all requirements of VHA Handbook 1100.19.

f. Follow VHA policies and procedures to ensure effective management, ethics, safety, communication, and quality within the Service.

g. Annually review privilege templates for each Service and make recommendations to the Professional Standards Board and Executive Committee of the Medical Staff.

3. Selection and Appointment of Associate Chiefs of Staff and Service Chiefs: Associate Chiefs of Staff and Service Chiefs are appointed based on the recommendation of the Chief of Staff in consultation with the Academic Partnership Council (formerly, Deans Committee), and with concurrence from the Medical Center Director.

4. Duties and Responsibilities of ACOSs and Service Chiefs: The Associate Chiefs of Staff (ACOS) lead overarching facility-wide programs at the SLVHCS, including but not limited to the ACOS-Ambulatory and Primary Care, ACOS-Research and Development, ACOS-Education, ACOS-Clinical Operations, and ACOS-Clinical Informatics. Each reports to the Chief of Staff. Additional ACOS positions can be added with the concurrence of the Medical Center Director.

5. The Service Chief is administratively responsible for the operation of the Service and its clinical, education and research efforts, as applicable. In addition to duties listed below, the Service Chief is responsible for ensuring that the Service performs according to applicable VHA performance standards. The ACOS/Service Chief must assure the highest level of professionalism and conduct among members of the Service. These are the performance requirements applicable to the Service from the national performance contract, and cascade from the overarching requirements delegated to the Chief of the Medical Staff. These requirements are described in individual Performance Plans for each Service Chief. Service Chiefs are responsible and accountable for:

   a. Clinically related activities of the Service.

   b. Assuring that each member of the Medical Staff meets all VA mandatory education requirements, maintains access to the VA network (including e-mail and the electronic medical record), provides appropriate resident supervision as required by the facility and meets all requirements contained in the Bylaws as applicable to each member of the Medical Staff as noted under Medical Staff Rules and Regulations

   c. Completing all applicable Medical Staff Leadership training within three months of appointment as Service Chief.

   d. The integration of the Service into the primary functions of the organization.

   e. The coordination and integration of interdepartmental and intradepartmental services.

   f. Administratively related activities of the department, unless otherwise provided by the organization.

   g. Continued surveillance of the professional performance of all individuals in the Service who have delineated clinical privileges through FPPE/OPPE.

   h. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Service.

   i. Recommending clinical privileges for each member of the Service based on demonstrated credentials

j. Assessing recommendations for off-site sources of needed patient care, treatment, and services not provided by the Service and communicating the recommendations to the relevant organizational authority.

k. The development and implementation of policies, manuals, and procedures that guide and support the provision of care, treatment, and services.

l. Ensuring the presence of a sufficient number of qualified and competent persons to provide care, treatment, and service.

m. The determination of the qualifications and competence of service personnel who are not licensed independent Practitioners and who provide patient care, treatment, and services.

n. The continuous assessment and improvement of the quality of care, patient safety, treatment, and services.

o. The maintenance of and contribution to quality control programs, as appropriate.

p. The orientation and continuing education of all persons in the service.

q. Advocating for space and other resources necessary for the service defined to be provided for the patients served.

r. Annual review of all clinical privilege forms to ensure that they correctly and adequately reflect the services being provided at the facility. This review is noted by date of review being included on the bottom of each privilege delineation form.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.

2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters unless otherwise set forth in these Bylaws.

3. The quorum requirement for all meetings shall be a majority of voting members, unless otherwise indicated in these Bylaws. The number requirement will be determined by the individual committee structure or governance.

4. The members of all standing committees, other than the Executive Committee of the Medical Staff (ECMS), are appointed by the Chief of Staff or Medical Center Director, subject to approval by the ECMS, unless otherwise stated in these Bylaws.

5. Unless otherwise set forth in these Bylaws, the Chair of each committee is appointed by the Chief of Staff or Medical Center Director.

6. Robert's Rules of Order will govern all committee meetings.

Section 5.02 Executive Committee of the Medical Staff *

1. Characteristics: The SLVHCS ECMS serves as the Executive Committee of the Medical Staff. An official list of the Medical Executive Committee membership is documented in SLVHCS Numbered Memorandum 00-101.

   a. Chief of Staff, Chairperson, voting.

   b. Members (Voting).

      1) Associate Chiefs of Staff and Service Chiefs,
      2) Associate Director for Patient Care Services
      3) Quality Manager

   c. Members (Non-Voting):

      1) Medical Center Director, ex-officio
      2) Chief, OI&T
      3) Representative, AFGE
      4) Representative, NFFE
      5) Patient Safety Manager
      6) Chief, Pharmacy Service
      7) Supervisor, Medical Staff Office
      8) Executive Assistant, COS.

   d. Other facility staff may be called upon to serve as resources or to attend committee meetings at the request of the Chair.

   e. The majority of the voting members must be fully licensed doctors of medicine or osteopathy.

   f. The Associate Chiefs of Staff, Service Chiefs and Chief of Staff appointees will serve on the Executive Committee of the Medical Staff as long as they are in good standing and hold their positions as clinical leaders.

   g. The Chief of Staff recommends the removal of the members that were appointed to the Committee.

h. When necessary, electronic voting using VA e-mail on a particular issue before the ECMS is permitted.

2. Functions of the Executive Committee of the Medical Staff:

a. Acts on behalf of the Medical Staff between Medical Staff meetings within the scope of its responsibilities as defined by the **organized Medical Staff**. The members of the Executive Committee of the Medical Staff will serve on the Committee as long as they are in good standing and hold their positions. The Chief of Staff will make the recommendations regarding the removal of membership.

b. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice; addresses the scope and quality of services provided within the facility.

c. Acts as a liaison between the Medical Staff and the Medical Center Director.

d. Makes recommendations directly to the Medical Center Director regarding the:

i) Organization, membership (to include termination), structure, and function of the Medical Staff. Procedures for the termination of Medical Staff membership are defined in Medical Center Memorandum No 05-14, "Admonishments, Reprimands, Major Adverse Actions and Probationary Reviews for Full-Time Employees Appointed under Title 38 U.S.C.""

ii) Process used to review credentials and determine privileges for the Medical Staff.

iii) Delineation of privileges for each Practitioner credentialed.

e. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration, VISN, performance measures, The Joint Commission, and relevant external standards required by accrediting bodies

f. Oversees process in place for instances of "for-cause" concerning a Medical Staff member's competence to perform requested privileges.

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

h. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.

i. Monitors Medical Staff ethics and self-governance actions.

j. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.

k. Receives and acts on reports and recommendations from Medical Staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups and makes needed recommendations to the Governing Body.

l. Assists in development of methods for care and protection of patients and others at the time of internal and external emergency or disaster, according to VA policies.

m. Acts upon recommendations from the Professional Standards Board.

n. Recommends physicians to serve as members of the Physical Standards Board, which evaluates the physical and mental fitness of Medical Staff referred by the Occupational Health Physician. The Physical Standards Board may have the same membership as the Professional Standards Board.

o. Provides oversight and guidance for fee basis and clinical contractual services.

p. Annually reviews and makes recommendations for approval of the Service-specific privilege lists.

3. Meetings:

a. Regular Meetings: Regular meetings of the Executive Committee of the Medical Staff shall be held monthly, at least 10 times per year. The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chair of the various committees of the Medical Staff shall attend regular meetings of the Executive Committee of the Medical Staff (ECMS) when necessary to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the ECMS.

b. Emergency Meetings: Emergency meetings of the Executive Committee of the Medical Staff may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meeting shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the Executive Committee of the Medical Staff, the Medical Center Director as the

Governing Body, or the Acting Chief of Staff, may call an emergency meeting of the Committee.

c. Meeting Notice: All Executive Committee of the Medical Staff members shall be provided at least 1 week's advance notice of the time, date, and place of each regular meeting and reasonable notice, oral or written, of each emergency meeting.

d. Agenda: The Chief of Staff, or in his or her absence, such other person as provided by these Bylaws, shall chair meetings of the Executive Committee of the Medical Staff. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.

e. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the Executive Committee of the Medical Staff shall be a majority of those voting members present. Action may be taken by majority vote at any meeting. The majority of the voting members must be fully licensed physicians of medicine or osteopathy. A physician designee can represent a voting member and vote.

f. Minutes: Written minutes shall be made and kept on all meetings of the Executive Committee of the Medical Staff, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff. The ECMS will review and vote on the minutes of the preceding meeting.

g. Communication of Action: The Chair at a meeting of the Executive Committee of the Medical Staff at which action is taken shall be responsible for communicating such action to any person who is directly affected by it

Section 5.03 Committees of the Medical Staff

1. The following Standing Committees hereby are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for medical staff membership, (e) reviewing the activities of the Medical Staff and Advanced Practice Professionals and Associated Health Practitioners (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners and (g) for such additional purposes as may be set forth in the charges to each committee:

a. Professional Standards Board:

i.) Charge: To consider requests for appointment, promotion, special advancements, summary action, and disciplinary action, and for granting, modifying, reappraising, reducing, revising, or revoking of clinical privileges for full-time, part-time, intermittent, without compensation, on-station, sharing agreement, consultant, on-station contract, or on-station fee-basis physicians; and granting, modifying, reappraising, reducing, revising or revoking of clinical privileges of dentists and podiatrists in the same employment categories of Southeast Louisiana Veterans Health Care System (SLVHCS). See SLVHCS NM 00-111.

ii.) Composition: Chief of Staff (Chairperson); Associate Chiefs of Staff and Clinical Service Chiefs. Non-voting member: NFFE Representative Administrative support is provided by Medical Staff Office personnel. Please see SLVHCS NM 00-111.

iii.) Meetings: Monthly or at the call of the Chairperson.

b. Pharmacy and Therapeutics Committee:

i) Charge: Recommend professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to pharmaceuticals; recommend programs designed to meet the needs of the professional staff of the Facility for complete current information on matters related to pharmaceuticals and current pharmaceutical practices See SLVHCS NM – 00-108. The full scope of P&T Committee responsibilities are detailed in VHA Handbook 1108.08, Feb 2009, VHA Formulary management process

ii) Composition: Members of clinical services, Nursing, Pharmacy, and Administrative Staff.

iii) Meetings: Monthly, no less than 10 times per year.

c. Peer Review for Quality Management Committee (formerly. Quality of Care Committee):

i) Charge: Review management of patients when a concern about such management has been raised. Peer review is defined as an organized process carried out by an individual health care professional or select committee of professionals, to evaluate the performance of other professionals. The Peer review committee is intended to promote confidential and non-punitive processes that consistently contribute to quality management efforts at the individual provider level (See VHA Directive 2010–025 Peer Review for Quality Management and SLVHCS NM 00-117)

ii) Composition: Chief of Staff (Chair), Service Chiefs or designees, Associate Director for Patient/Nursing Services, Risk Manager, Nurse Practitioners.

iii) Meetings: Monthly, no less than 10 times per year.

d. Infection Control and Prevention Committee:

i) Charge: Define, survey, correlate, review, evaluate, revise and institute whatever recommendations are necessary in order to prevent, contain, investigate and control nosocomial infections and other infectious diseases among patients and personnel; submit committee minutes to the Executive Committee of the Medical Staff, no less than every two months and report a summary of its activities to the ECMS, at least annually. See SLVHCS NM 00-114 and VHA intranet site: vaww.va.gov/INFECTIOUSDISEASES/IPC.asp

ii) Composition: Infection control officer and other members of the Medical Staff including Chief, Infectious Disease, members of Patient/Nursing Services, Pathology and Laboratory Medicine, Environmental Management, Food and Nutrition, Pharmacy Services..

iii) Meetings: at least every two months.

e. Cancer Care Committee

i) Charge: The Cancer Committee ensures that the infrastructure, organizational structure and policies of SLVHCS support the delivery of the highest standard of oncology care. The Cancer Committee serves as the governing body of the cancer program and its components. This multidisciplinary committee has the responsibility of initiating, stimulating and assessing the Cancer Program activities in SLVHCS. This committee is responsible for the overall supervision of the facility's Cancer Registry. The Committee implements the requirements for an approved program based on the Commission on Cancer "Cancer Programs Standards 2009 revised edition" and the "Facility Oncology Registry Data Standards (FORDS) revised for 2015." The Cancer Committee meets on a quarterly basis as an entity separate from conferences or tumor boards, and documents its activities and attendance. In addition, the Cancer Committee oversees issues related to the Cancer Clinical Research being conducted in the medical center. See SLVHCS NM-00-110 and VHA Directive 2003-034, National Cancer Strategy.

ii) Composition: The Cancer Committee is composed of physicians and representatives from the diagnostic and therapeutic specialties, as well as allied health professionals involved in the care of cancer patients. Membership is at the discretion of the Cancer Committee Chair. One physician representative is required from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, and Pathology. Non-physician membership must include an Administrator, Nursing, Social Services, Tumor Registry and Quality Assurance.

iii) Meetings: At least quarterly.

f. Medical Records Committee

i) Charge: Oversee process for maintenance and completion of medical records. Review results of medical record audits and recommend improvements based on these results. Approve electronic medical record templates and titles. See SLVHCS NM 00-112

ii) Composition: Physician representation, Quality Management, Patient/Nursing Care Services, Dental Service, Medicine, Surgery, Ambulatory and Primary Care, Mental Health, Pharmacy, Chief Health Information Management Section (HIMS), Education/Academic Affiliations (from the standpoint of Resident Supervision), Compliance office

iii) Meetings: At least 10 times a year

g. Facility Surgical Workgroup (formerly, Operative/Invasive Procedure Committee)

i) Charge: The Facility Surgical Work Group supports the VISN Surgical Work Group to integrate surgical quality improvement data, improve practice and patient safety, and ensure communication at the facility level to the VISN and National Surgical Office. See SLVHCS NM 00-113 and VHA Handbook 1102.01, pages 9-11 (Jan 2013) and VHA Directive 1039 July 26, 2013

ii) Composition: Chaired by the Chief, Surgery Service. Membership must include, but is not limited to the Chief of Staff, Surgical Quality Nurses and OR Nurse Managers.

iii) Meetings: at least monthly

h. Research and Development Committee:

i) Charge: Oversight of all research programs conducted at, or under the auspices of SLVHCS and the VA Gulf Coast Veterans Health Care System. The following subcommittees report to the Research and Development (R&D) Committee: Institutional Review Board for Human Studies Subcommittee; Institutional Animal Care and Use Committee; Research and Development Equipment Committee; Research Safety Committee (SRS); Research and Development Budget Subcommittee; and Research and Development Space Subcommittee. Subcommittee. Further details of R&DC and its membership are defined in VHA Handbook 1200.01, June 16, 2009, Research and Development Committee and SLVHCS NM 00-116.

ii) Composition: Voting members include Chair and Vice Chair of R&D Committee, and one member with an academic appointment with the affiliate. Non-voting ex-officio members include the Medical Center Director of both VA facilities, Chief of Staff of both VA facilities, Administrative Officer/R&D for both VA facilities, Research Compliance Officer.

iii) Meetings: Monthly with a minimum of 11 meetings per year.

i. Disruptive Behavior Committee

i) Charge: The Disruptive Behavior Committee (DBC) conducts individualized violence risk and threat assessments to determine the likelihood that a patient's disruptive behavior will undermine safety in VA. The DBC is also responsible to forward violence risk mitigation strategy recommendations to the facility's COS in order to promote the delivery of safe healthcare. The DBC recommends therapeutic limit-setting actions to the COS and provides consultation to VA staff working with patients who demonstrate disruptive behaviors or pose a risk of disruptive behavior. The primary goal of the DBC is to assist the disruptive patient to receive a range of available health care while reducing the risk of disruptive or violent behavior to others. The DBC is also responsible for coordinating Prevention and Management of Disruptive Behavior (PMDB) employee training and review patients with a history of disruptive behavior, and determine need for national patient record "flags" (PRFs) in patients' medical records. See SLVHCS NM 00-119.

ii) Composition: Members of clinical services, including Mental Health, Patient Safety Manager,, Employee Assistant Program Coordinator, Regional Council, Police Service, and Administrative Staff

iii) Meetings: Monthly

j. Ancillary (Point of Care or Waived) Testing Committee

i) Charge: Ancillary testing is defined as laboratory testing within a VA medical center or its outreach functions that is performed outside the physical facilities of the main clinical laboratory for diagnostic, screening, monitoring, and other patient care purposes. Ancillary testing is also referred to as point-of-care testing or waived testing. All ancillary testing is under the technical direction and quality management oversight of the Chief, Pathology and Laboratory Medicine Service (VHA Directive 1106, 2013 and SLVHCS NM 00-120)

ii) Composition: Chaired by Chief, Pathology and Laboratory Service. Voting Members include Ancillary Testing Coordinator, Chief of Medicine, Chief of Ambulatory and Primary Care, Chief of Logistics, Workforce Development Coordinator, Administrative Officer to the Chief of Staff, Medical Director of PPM Laboratories, and others as outlined in NM 00-120.

iii) Meetings: Annually

k. Interdisciplinary Pain Committee

i) Charge: The primary objective of the Committee is to serve as a resource for pain management and to ensure consistency with the VISN, VHA, TJC and CARF Medical Rehabilitation standards of care. The Committee oversees, coordinates, and monitors pain management processes at the SLVHCS to ensure consistency with the VHA Directive 2009-053 (Pain Management), promotes a system-wide, interdisciplinary approach to pain assessment and

management by promoting communication among SLVHCS staff, promotes processes and outcomes of pain management with a goal of continuous improvement and provides support to services for the development and dissemination of state-of-the-art treatment protocols. The Committee also assists in coordination of educational activities that promote clinician expertise in pain assessment and treatment, and monitors the safe and effective use of opioid medications for chronic non-cancer pain and the opioid safety initiative. See SLVHCS NM 00-18 and VHA Directive 2009-053

ii) Composition: Chair is the Chief, Pain Medicine Section. Representation from Clinical services, including Mental Health, Anesthesiology, Neurology, Neurosurgery, Orthopedics, Physical Medicine and Rehabilitation, Ambulatory and Primary Care, Nursing, and Pharmacy

iii) Meetings: Monthly

l. Women Veterans Committee

i) Charge: To provide oversight, evaluation, guidance, and comprehensive planning for women's health issues that improves the overall quality of care provided to women Veterans and to provide recommendations to leadership for improving services and programs for women Veterans. See VHA Handbook 1330.01, May 21, 2010 and SLVHCS NM 00-115.

ii) Composition: Chaired by the Women Veterans Health Program Manager with membership from Clinical services, Volunteer office, Associate Director Patient Care Services, Radiology, Consumer Representatives,

iii) Meetings: quarterly

m. Graduate Medical Education Committee

i) Charge: To provide oversight of the facility's GME programs and review quality of programs, supervision and learner's perception.

ii) Composition: ACOS-Education, Residency Program Coordinators and others as selected by the ACOS-E.

iii) Meetings: every other month

COMMITTEES TO BE CONSTITUTED BY ACTION OF PROJECT LEGACY

n. Moderate Sedation Committee

i) Charge: To ensure that compliance with moderate sedation monitoring requirements is met and reinforced as contained in VHA Directive 1073, Dec 2014, Moderate Sedation by Non-anesthesia Providers. All Services utilizing moderate sedation shall report quarterly to the Moderate Sedation

Committee. These reports will include at a minimum the number of procedures performed involving moderate sedation, number of times sedation antagonists are used, number of unplanned hospital admissions following moderate sedation, adverse outcomes deaths, medication errors, allergic reactions and falls associated with moderate sedation procedures and the number of Code calls, unplanned intubations, or use of bag-mask device for resuscitation

ii) Composition: To be determined by the Chief of Staff.

iii) Meetings: As recommended by the Chief of Staff.

o. Radiation Safety Committee

i) Charge: Responsible for ensuring that all practices and procedures involving the use of radioactive materials are conducted in such a manner as to ensure radiation exposure to both the occupational worker and general public is As Low As Reasonably Achievable (ALARA) and in accordance with Federal, State and local regulations. See VHA Directive 1105, Feb 2015. The Laser Safety Program and Fluoroscopy safety programs report to the Committee. (VHA Handbook 1105.04July 2012, Fluoroscopy Safety and VHA Handbook 7701.1 2010 Occupational Safety and Health (OSH) Program Procedures)

ii) Composition: To be determined by the Chief of Staff.

iii) Meetings: As recommended by the Chief of Staff

p. Critical Care Committee (includes CRS/RRT)

i) Charge: Review quality of care in medical and surgical intensive care units and step-down units, as well as the performance of the code and rapid response teams. The committee will assure that SLVHCS provides excellent, efficient, and timely care to patients requiring the specialized services provided within the critical care programs and to continually assess and improve clinical outcomes, process design and patient, family and staff satisfaction

ii) Composition: To be determined by the Chief of Staff.

iii) Meetings: As recommended by the Chief of Staff

q. Health Information Management Committee (formerly, Medical Records Committee)

i) Charge: Provides oversight for the patient medical record system including records kept in traditional "paper" file systems and patient-specific information filed electronically in the Veterans Health Information Systems and Technology (VISTA) system. The Committee ensures accurate, timely and complete documentation through the medical record review process and

maintains the integrity of the information in the patient treatment file (PTF) and Patient Care Encounter (PCE) systems, utilizing ICD-10-CM and CPT4 coding as appropriate. Provides guidance to administrative and medical staff as appropriate on medical record issues and provides transcription, coding/abstracting and filing/retrieval services for the medical center.

ii) Composition: Chaired by ACOS-Clinical Informatics

iv) Meetings: As recommended by Chief of Staff-CI

r. Out-of-operating room invasive procedures

i) Charge: The quality, appropriateness and safety of out-of-operating room invasive procedures as well as diagnostic and therapeutic procedures of an invasive nature will be monitored and evaluated through an ongoing systematic process to minimize clinical risks to patients and assure comparability of care. The Committee is functionally responsible for oversight of operative, diagnostic and therapeutic procedures conducted out-of-operating room within SLVHCS. The review of processes and outcomes will be systematic, organization-wide, collaborative and interdisciplinary. The scope of the committee activities encompasses invasive procedures in which general, spinal, or major regional anesthesia, moderate or deep sedation is utilized in accordance with VHA Directive 1039 July 26, 2013. The Committee will do a comprehensive pathology review (tissue/cytology) and establish processes to systematically review and evaluate the clinical outcomes of procedures including, but not necessarily limited to:

- Selecting appropriate procedures;
- Preparing patients for procedures;
- Performing procedures safely;
- Patient monitoring during the procedure based on approved guidelines and standards of practice for sedation, or analgesia, as applicable;
- Providing post-procedure care and determining appropriate disposition of patients
- Post-procedure patient education
- Review of tissue sent to pathology for discrepancies and irregularities

ii) Composition: To be determined by Chief of Staff

iii) Meetings: To be determined by Chief of Staff

s. Transfusion Utilization Committee (formerly, Blood Utilization Committee)

i) Charge: Establish broad policies for the transfusion therapy and assess blood and blood component use as well as adverse reactions or outcomes. The Committee must meet all requirements of VHA Directive 1185, September, 2015 and AABB Standards for Blood Banks and Transfusion Services, 29th edition, 2014

ii) Composition: To be determined by Chief of Staff

iii) Meetings: As recommended by Chief of Staff

2. Information Flow to Executive Committee of the Medical Staff (ECMS): All Medical Staff Committees, including but not limited to those listed above, will submit minutes of all meetings to the ECMS in a timely fashion after the minutes are approved and will submit such other reports and documents as required and/or requested by the ECMS.

Section 5.04 Committee Records and Minutes

1. Committees prepare and maintain reports to include data, conclusions, recommendations, responsible person, actions taken, and evaluation of results of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on a quarterly basis.

2. Each committee shall review and forward to the ECMS a synopsis of any subcommittee and/or workgroup findings.

Section 5.05 Establishment of Committees

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

ARTICLE VI. MEDICAL STAFF MEETINGS

1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least annually. A record of attendance shall be kept.

2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Medical Center Director or the ECMS. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least forty-eight (48) hours prior thereto. Members of

the Medical Staff may request a special meeting either through the Chief of Staff or Medical Center Director in writing and stating the reason(s) for the request.

3. Quorum: For purposes of Medical Staff business, the quorum requirements for all meetings shall be a majority of those voting members present.

4. Meeting Attendance: Members of the Organized Medical Staff are required to attend the annual regular meeting of the Medical Staff.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING *

Section 7.01 General Provisions

1. Independent Entity: The Southeast Louisiana Veterans Health Care System (SLVHCS) is an independent entity, granting privileges to the Medical Staff through the PSB and the ECMS and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Advanced Practice Professional and Associated Health Practitioner reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff and Advanced Practice Professionals and Associated Health Practitioners must practice under their privileges or scope of practice.

2. Credentials Review: Credentialing refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, registration, certification, required education, relevant training and experience, and current competence. NOTE: Practitioners who are not directly involved in patient care (i.e., researchers or administrative personnel), but by the nature of their position, have the potential to assume patient care-related duties, or oversee the quality or safety of the patient care delivered, must be credentialed. (The VHA expanded the credentialing process to all licensed, registered, and certified health care professionals as a described in VHA Directive 2012-030, Credentialing of Health Care Professionals and VHA Handbook 1100.19, October 2012. See Attachment B for a list of all occupations covered by credentialing). Also see VHA Office of Quality, Safety & Value Medical Staff Affairs (Credentialing &Privileging) at http://vaww.oqsv.med.va.gov/Default.aspx > Safety and Risk Awareness (10A4E) > Medical Staff Affairs.

   All Licensed Independent Practitioners (LIP), and all Advanced Practice Professionals and Associated Health Practitioners who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of proposed initial appointment and reappraisal for granting of clinical privileges and upon returning after a break in service (severing or terminating of a medical staff appointment). All Advanced Practice Professionals and Associated Health Practitioners will be subjected to full credentials review at the time of initial

appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a maximum period of 2 years.

3. Deployment/Activation Status:
   a. When a member of the Medical Staff has been deployed to active duty, upon notification, the privileges will be placed in a "Deployment/Activation Status" and the credentialing file will remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Practitioner will update the credentialing file to current status.
   b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the PSB (then to ECMS) for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.
   c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.
   d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service 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. These providers may be returned to a pay status on return from active duty, but may not be in direct patient care until their ability to perform privileges that they are requesting has been validated.
4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:
   a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.
   b. Federal law authorizing VA to contract for health care services.
5. Focused Professional Practice Evaluation:
   a. The **initial** focused professional practice evaluation (FPPE) is a process whereby the Medical Staff evaluates the scope of practice—or privilege-specific competence of a Practitioner who does not have documented evidence of

competently performing the requested scope of practice privilege at the organization. For all new privileges granted, an FPPE is required. This occurs with a new Practitioner or an existing Practitioner who request a new privilege or scope of practice. The performance monitoring process is defined by each Service and must include;

i) Criteria for conducting performance monitoring

ii) Method for establishing a monitoring plan specific to the requested privilege

iii) Method for determining the duration of the performance monitoring

iv) Circumstances under which monitoring by an external source is required.

NOTE: The FPPE typically occurs at the time of initial appointment to the medical staff, or the granting of new, additional privileges. In contrast to the initial FPPE, a focused professional practice evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

b. An initial Medical Staff appointment does not equate to HR employment. FPPE does not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below;

i) Initial and certain other appointments made under 38 U.S.C. 7401(l), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations.

ii) If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply the same processes to the evaluation of individuals employed under provision of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.

Reference: VHA HANDBOOK 1100.19, October 15, 2012

6. Ongoing Professional Practice Evaluation:

The on-going monitoring of privileged practitioners is essential to confirm the quality of care delivered. This is called the Ongoing Professional Practice Evaluation (OPPE). This allows the facility to identify professional practice trends that impact the quality of care and patient safety. Such identification may require intervention by the Medical Staff leadership. Criteria-based privileges or scope of practice make the on-going monitoring of competence easier for Medical Staff leadership. Each Service Chief should consider what hospital, regional, state, national, and specialty standards, activities, and data are available to meet these needs. The maintenance of Board certification is not sufficient in and of itself. There are a number of activities such as direct observation, clinical discussions, and clinical pertinence reviews that, if documented, can also be incorporated into the on-going monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.

a. The timeframe for ongoing monitoring will be every six months. It is suggested that, at a minimum, Service Chiefs must be able to demonstrate that relevant practitioner data are reviewed on regular basis. OPPE data has to be formally reported to the PSB at the time of medical staff reappointment even though it is an ongoing process. Each clinical Service must keep OPPE data and have it available for review (in addition to providing it for reappointment). Consideration may be based on a period of time or a specified number of procedures, and may consider high risk or high volume for an adjustment to the frequency.

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

c. In those instances where a practitioner does not meet established criteria, the Service Chief has the responsibility to document areas of concern. These situations can occur for a number of reasons and do not preclude a Service Chief from recommending the renewal of privileges, but that individual must clearly document the basis for the recommendation of renewal of privileges.

d. The Executive Committee of the Medical Staff (ECMS) must consider all information available, including the Service Chief's recommendation and reasons for renewal when criteria have not been met, prior to making a recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes of the ECMS.

e. The Director shall weigh all information available, as well as the recommendations, in the determination of whether or not to approve the renewal of privileges and document this consideration.

Reference: VHA HANDBOOK 1100.19, October 15, 2012

Section 7.02 Application Procedures *

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete application. The applicant is bound to be forthcoming, honest and truthful. To be complete, applications for appointment must be submitted by the

applicant on SLVHCS and/or VHA approved forms. **VetPro** is an Internet enabled data bank for the credentialing of VHA personnel that facilitates completion of a uniform, accurate, complete credential file. Submission of credentials in the VetPro Credentialing System is required of all VHA licensed, registered, and certified health care providers. The application includes authorization for release of information pertinent to the applicant and information listed below. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct.

a. Items specified in Article III, Section 2, Qualifications for Medical Staff Membership, including:

   i) Active, Current, Full, and Unrestricted License

   ii) Education.

   iii) Relevant training and/or experience.

   iv) Current professional competence and conduct.

   v) Physical and Mental health status.

   vi) English language proficiency.

   vii) Professional liability insurance (contractors only).

   viii) BLS approved program using criteria by the American Heart Association (as outlined in SLVHCS NM 002C-05).

   ix) To qualify for moderate sedation and airway management privileges, the Practitioner will have specific, approved clinical privileges and will acknowledge that they have received a copy of "The Sedation and Analgesia by Non-Anesthesia Providers" policy and agree to the guidelines outlined in the policy.

b. U.S. Citizenship: Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, Practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment with proof of current visa status and appropriate federal agency documentation regarding employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Handbook 5005, Part II, Chapter 3.

c. References (see 2a below, Primary Source Verification): The names and addresses of at least four (4) individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer and for individuals completing a residency, one reference must come from the residency training program director. The Facility Director may require additional information.

d. Previous Employment: A list of all health care institutions or other organizations where the Practitioner is/has been appointed, utilized or employed (held a professional appointment), including:

   i) Name of health care institution or practice.

   ii) Term of appointment or employment and reason for departure.

   iii) Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary surrender.

e. Drug Enforcement Administration / Controlled Dangerous Substances (DEA/CDS) Registration:

   i) Status, either current or inactive.

   ii) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, the Practitioner's DEA/CDS registration.

f. Sanctions or Limitations: Any sanction or penalty by any licensing authority, including current pending challenges, whether a license or registration ever held to practice a health occupation by the Practitioner has been suspended, revoked, voluntarily surrendered, or not renewed.

g. Liability Claims History: Status (Open, Pending, Closed, Dismissed, etc.) of any claims made against the Practitioner in the practice of any health occupation including final judgments or settlements, if available.

h. Loss of Privileges: Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility.

i. Release of Information: Authorization for release of information, including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.

j. Pending Challenges: Pending challenges against the Practitioner by any hospital, licensing agency, professional group, or society.

2. Primary Source Verification: In accordance with VHA Handbook 1100.19 Credentialing and Privileging and VA Handbook 5005, Part II, Chapter 3 the facility will obtain primary source verification of:

   a. A minimum of three (3) references for initial credentialing, and two (2) for re-credentialing, from individuals able to provide authoritative information regarding information as described in Article VIII, Section 8.02.

   b. Verification of current or most recent clinical privileges held, if available.

   c. Verification of status of all licenses current and previously held by the applicant.

   d. Evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate for foreign medical graduates, if claimed.

e. Evidence and verification of Board certification or successful completion of accredited residency training, if applicable.

f. Verification of education credentials used to qualify for appointment including all postgraduate training.

g. Evidence of registration with the National Practitioner Data Bank (NPDB) Continuous Query Update for all members of the Medical Staff and those Practitioners with clinical privileges.

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

i. Confirmation of health status on file as documented by a physician or nurse practitioner approved by the Organized Medical Staff.

j. Evidence and verification of the status of any alleged or confirmed malpractice. It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the Practitioner, requesting all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the Practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint. Questions concerning applicants, who may qualify for appointment under the Rehabilitation Act of 1974, need to be referred to Regional Counsel.

k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made.

3. The applicant's attestation to the accuracy and completeness of the information submitted.

4. Burden of Proof: The applicant has the burden of obtaining and producing all needed information for a proper evaluation of the applicant's professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within 30 days of the request to the applicant may serve as a basis for denial of employment consideration.

5. VetPro Required: All healthcare providers must submit credentialing information into VetPro as required by VHA policy.

Section 7.03 Process and Terms of Appointment *

1. 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 completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met. The Service Chief must complete the appropriate sections of VETPRO.

2. VISN 16 CMO Review: On May 6, 2013, NPDB and HIPDB merged into one database referred to as NPDB. If a response from the NPDB continuous query indicates that any of the following criteria are 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 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 Executive Committee of the Medical Staff (ECMS). The higher level review by the VISN CMO is to assure that all circumstances, including the individual's explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN CMO review will be documented on the Service Chief's Approval screen in VetPro as an additional entry. Review by the CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

3. ECMS Recommendation: The PSB recommends to the Executive Committee of the Medical Staff a Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
4. Director Action: Recommended appointments to the Medical Staff should be acted upon by the 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 from the Executive Committee of the Medical Staff.

5. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment, or return of the application because of inadequate information.

Section 7.04 Credentials Evaluation and Maintenance *

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

2. Good Faith Effort to Verify Credentials: A good faith effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as successful verification, or satisfactory evidence, that verification is not possible (records destroyed, health care institution closed, private practice partner deceased, etc.). When it is not possible to obtain documentation, an entry will be placed in the file stating the reason and a secondary source will be sought. The entry will describe the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. It will also indicate when a secondary source, e.g. copy of diploma, confirmation from someone in practice or training at the same time, is being used in lieu of primary-source verification. The applicant should assist in providing required information for this documentation. Verification of licensure from primary source(s) is necessary.

3. Maintenance of Files: A complete and current Credentialing and Privileging (C&P) file including the VetPro file will be established and maintained for each provider requesting privileges. Maintenance of the file is the responsibility of the Medical Staff office that reports to the Chief of Staff. Any time a file is found to lack required documentation, without an entry as noted above in paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain the documentation.

4. Focused Professional Practice Evaluation: A Focused Professional Practice Evaluation (FPPE) will be initiated at time of initial appointment with privileges, at the time of request for additional privileges, or in case of a "for-cause" event requiring a focused review.

   a. An FPPE, implemented at time of initial appointment, will be based on the Practitioner's previous experience and competence. The evaluation can be defined as comprising a specific time frame, number of procedures or cases, chart reviews, etc. and should be discussed with the Practitioner by the Service Chief.

   b. An FPPE at the time of request for additional privileges will be for a period of time, a number of procedures, and/or chart review to be set by the Service Chief.

c. An FPPE initiated by a "for-cause" event will be set by the Service Chief. FPPE for cause ,where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges e.g., summary suspension

d. The FPPE monitoring process will clearly define and include the following:

   i) Criteria for conducting the FPPE.

   ii) Method for monitoring for specifics of requested privilege(s).

   iii) Statement of the "triggers" for which a "for-cause" FPPE is required.

   iv) Measures necessary to resolve performance issues which will be consistently implemented.

e. Information resulting from the FPPE process will be integrated into the Service specific performance improvement program, consistent with the Service's policies and procedures.

f. If at any time the Service Chief or designee cannot determine the competence of the Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:

   i) Extension of FPPE review period

   ii) Modification of FPPE criteria

   iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner)

   iv) Termination of existing privileges (appropriate due process will be afforded to the Practitioner, and appropriate documentation and reporting will be implemented).

Reference: VHA HANDBOOK 1100.19, October 15, 2012

Section 7.05 Local/VISN-Level Compensation Panels

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

ARTICLE VIII CLINICAL PRIVILEGES *

Section 8.01 General Provisions

1. Clinical privileges are granted for a period of no more than 2 years.

2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.
   a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.
   b. Reappraisal requires documentation of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.
   c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Executive Committee of the Medical Staff. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7).

3. A Practitioner may request modification or accretion of existing clinical privileges by submitting a formal request for the desired change(s) with full documentation to support the change to the Service Chief

4. Associated Health and Advanced Practice Professionals who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privileges and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.

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

6. Practitioners with clinical privileges are approved for and have clinical privileges in one clinical Service but may be granted clinical privileges in other clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In

those instances where clinical privileges cross to a different designated service, all Service Chiefs must recommend the practice.

7. Exercise of clinical privileges within any Service is subject to the rules of that Service and to the authority of that Service Chief.

8. When certain clinical privileges are contingent upon appointment to the faculty of an affiliate, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.

9. Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies.

10. 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.

Section 8.02 Process and Requirements for Requesting Clinical Privileges *

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

3. Credentialing Application: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
   a. Complete appointment information as outlined in Section 2 of Article VI.
   b. Application for clinical privileges as outlined in this Article.
   c. Evidence of professional training and experience in support of privileges requested.

d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Executive Committee of the Medical Staff.

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

f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

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

h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

i. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association.

4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.

5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that he/she has received a copy of Sedation and Analgesia by Non-Anesthesia Providers policy and agree to the guidelines outlined in the policy and in VHA Directive 1073, December 30, 2014

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

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:

a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the

appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.

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

c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Executive Committee of the Medical Staff

d. 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.

e. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

f. Names and addresses of two peers who are qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

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

2. Verification: Before granting subsequent clinical privileges, the Credentialing and Privileging Office will ensure that the following information is on file and verified with primary sources, as applicable:

a. Current and previously held licenses in all states.

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

c. NPDB-Continuous Query Registration.

d. FSMB query

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

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

h. Continuous education to meet any local requirements for privileges requested.

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges *

1. A Practitioner's request for modification or accretion of, or addition to, existing clinical privileges is initiated by the Practitioner's submission of a formal request for the desired change(s) with full documentation to support the change to the Clinical Service Chief. This request will initiate the recredentialing process as noted in the VHA Handbook 1100.19.

2. Primary source verification is conducted if applicable, e.g. provider attests to additional training.

3. Current NPDB- Continuous Query Registration prior to rendering a decision.

4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Executive Committee of the Medical Staff followed by the Medical Center Director's/Governing Body's approval.

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

1. Peer recommendations from individuals who can provide authoritative information regarding training, experience, professional competence, conduct, and health status are required.

2. The Service Chief where the applicant is requesting clinical privileges is responsible for assessing all information and making a recommendation regarding whether to grant the clinical privileges.

   a. Recommendations for initial, renewal or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:

      1. Medical/Clinical Knowledge
      2. Interpersonal and Communication skills

3. Professionalism
4. Patient Care
5. Practice-based Learning & Improvement
6. System-based Practice

b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, professional performance, judgment, clinical and/or technical skills and quality of care including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE.

3. Executive Committee of the Medical Staff (ECMS) or the committee responsible for the Medical Executive Function, recommends granting clinical privileges to the Facility Director (Governing Body) based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. A subcommittee of ECMS can make the initial review and recommendation but this information must be reviewed and approved by the ECMS

4. Clinical privileges are acted upon by the Medical Director within 30 calendar days of receipt of the ECMS recommendation to appoint. The Medical Center Director's action must be verified with an original signature.

5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A Copy of approved privileges is given to the Practitioner and is readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.

Section 8.06 Exceptions*

1. Temporary Appointment and Privileges for Urgent Patient Care Needs: Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of an initial appointment for a limited period of time (not to exceed 60 calendar days) by the Medical Center Director or Acting Medical Center Director on the recommendation of the Chief of Staff.

   a. Temporary privileges are based on verification of the following:

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

iii) One reference from a peer who is knowledgeable of and confirms the Practitioner's competence and who has reason to know the individual's professional qualifications.

iv) Current comparable clinical privileges at another institution.

v) Response from NPDB–Continuous Query Registration with no match.

vi) Response from FSMB with no reports.

vii) No current or previously successful challenges to licensure.

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

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

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

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

2. <u>Expedited Appointments:</u>

a. The Practitioner must submit a completed application through VetPro.

b. The Facility:

i) Verifies education and training;

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

iii) Receives confirmation on the declaration of health, by a physician designated by or acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought;

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

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

vi) Verifies current comparable privileges held in another institution; and

vii) Receives a response from NPDB-Continuous Query Registration with no match.

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

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

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

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

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

d. The recommendation by the delegated subcommittee of the Executive Committee of the Medical Staff must be acted upon by the Medical Center Director.

e. Full credentialing must be completed within 60 calendar days of the date of the Medical Center Director's/Governing Body's signature and presented to the Executive Committee of the Medical Staff for ratification.

3. Emergency Care: Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.

4. Disaster Privileges: As described in VHA Handbook, 1100.19, Credentialing and Privileging and the Facility's Emergency Management Plan and outlined in NM 11-11 Attachment G. This process applies only when the facility's disaster or emergency plan has been implemented.

   a. Licensed independent practitioners who volunteer to render emergency care to our patients at the time of a disaster, and who are not privileged members of the medical staff, must be identified (and credentialed when possible) as follows before temporary disaster privileges can be granted. These LIPs will be assigned to a "partner;" a Medical Staff Member or Allied Health Provider (as specified in the Bylaws) in the same specialty if possible, with whom to collaborate in the care of disaster victims.

i) The Chief of Staff or designee is responsible for granting temporary disaster privileges.

ii) Once the facility Disaster or Emergency Plan has been initiated, a packet of application forms and labels, maintained at the Command Post, will be made available to the designee for identifying and accepting licensed independent practitioners who wish to volunteer.

(1) The packet contains numbered applications for Temporary Disaster Privileges, labels that will be used to identify those LIP volunteers and carbon paper in the event a copier is not available.

(2) The designee is responsible for reviewing the volunteer's identification as stated in paragraph 2, and entering the data onto the application form.

b. Identification: At least one or more of the following forms of identification must be sighted (copied and verified if conditions permit) prior to granting privileges to provide patient care:

i) Current picture hospital identification card with discipline or professional degree indicated (i.e. MD or DO for physicians, DDS or DMD for Dentists, DPM for Podiatrists, PhD or PsyD for Psychologists, LCSW for Social Workers, AUD for Audiologists, SLP for Speech Pathologists);

(1) or Government-issued photo identification (e.g., expert physician from the CDC, Disaster Medical Assistance Team, or other response group);

(2) or current professional license to practice in any state and photo identification such as a driver's license, passport or military ID card;

(3) or identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (authority granted by a federal, state or municipal entity);

(4) or the practitioner is presented by a currently credentialed and privileged member of our medical staff with personal knowledge of the practitioner's identity.

ii) Verification of identification should be completed by Medical Staff Office personnel as soon as the immediate situation is under control, either through the credentialing process outlined in paragraph 4 below, or by direct contact with the issuing authority.

c. Privileges: Temporary disaster privileges may be granted to an appropriately identified practitioner as noted above based upon the needs of the Health Care System to augment staffing due to a disaster situation.

i) Privileges are to render appropriate emergency care.

ii) Approvals will be documented on the Temporary Disaster Privileges form.

(1) The volunteer should wear the Temporary Disaster Privileges label on the picture identification they are using so that health care system staff is able to easily identify LIP Disaster Volunteers granted disaster privileges

(2) If the situation permits, a copy of the Temporary Disaster Privileges form will be made, and if a copy cannot be made, then the form should be completed in duplicate, with one copy for the provider and one copy to the Medical Staff Office or granting authority.

(3) Blank forms are numbered for accountability and will be available at the Disaster Command Post, along with carbon paper and labels.

(4) After the application form is completed noting the identification sighted, and privileges are approved, a label will be placed on the LIP Disaster Volunteer's current identification, permitting existing medical staff to easily identify LIP Disaster Volunteers granted privileges.

iii) When the emergency situation no longer exists, or when patients are out of imminent danger of death or serious deterioration of condition (determined by each service), or when Medical Staff members can adequately provide care, temporary disaster privileges terminate (generally no longer than one week). The Service Chief or designee will notify LIP Disaster Volunteers of termination of their temporary privileges.

iv) Refer to **NM 11-11**, Attachment G for a sample Temporary Disaster Privileges Application Form, including a consent and release of information statement and sample Temporary Disaster Privileges Label.

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

a. When the Practitioner returns to the Facility, 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.

b. At the time of inactivation of privileges, including separation from the medical staff, the Facility Director ensures that within 7 calendar days of the date of separation, information is received suggesting that Practitioner met generally accepted standards of clinical practice and there is no reasonable concern for the safety of patients in accordance with VHA Handbook 1100.18.

6. Deployment and Activation Privilege Status: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment

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

b. After the electronic credentials file has been reopened for credentialing, the Practitioner must update the licensure information, health status, and professional activities while on active duty.

c. The credentials file must be brought to a verified status. If the Practitioner performed clinical work while on active duty, an attempt is made to confirm the type of duties, the Practitioner's physical and mental ability to perform these duties, and the quality of the work. This information must be documented.

d. The verified credentials, the Practitioner's request for returning the privileges to an Active Status, and the Service Chief's recommendation are presented to the Executive Committee of the Medical Staff for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the Executive Committee of the Medical Staff is documented and forwarded to the Medical Center Director for recommendation and approval of restoring the Practitioner's privileges to Current and Active Status from Deployment and/or Activation Status.

e. In those instances when the Practitioner's privileges did not expire during deployment, the expiration date of the original clinical privileges at the time of deployment continues to be the date of expiration of the restored clinical privileges.

f. In those instances where the privileges lapsed during the call to active duty, the Practitioner needs to provide additional references for verification and Facility staff need to perform all verifications required for reappointment.

g. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief, must consider whether a request for modification of the privileges held prior to the call to active duty should be initiated on a short-term basis.

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

   i) Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.
   ii) Registration with the NPDB-Continuous Query with no match.
   iii) A response from the FSMB with no match.
   iv) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.
   v) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

Section 8.07 Medical Assessment

A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The initial and the updated examination of the patient, 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 state law, VHA and hospital policy. The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.

ARTICLE IX INVESTIGATION, SUMMARY SUSPENSION AND ACTION*

Section 9.01

NOTE: Article IX addresses the process to be used when the potential for a clinical care concern has been identified. 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.

1. Concerns Identified: Whenever there are concerns that a Practitioner 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 Chief of Staff or the Medical Center Director may also initiate a preliminary fact-finding.

2. Documentation: 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 comprehensive focused clinical care review. These findings may result in an administrative action.

   a. 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.

   b. 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.

3. Summary Suspension of Privileges: The Medical Center 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 paragraph 6 below):

a. 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 result in an imminent danger to the safety and welfare of an individual.

b. 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 for the action being taken. 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.

c. 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, and a summary suspension of clinical privileges letter must be issued to the Practitioner immediately.)

d. 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.

e. The written notification of summary suspension of clinical privileges affords the Practitioner of the opportunity to submit, within14 calendar days from receipt of the summary suspension notification letter, a written response to the concerns identified within the letter.

f. Upon receipt of the Practitioner's 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.

4. 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).

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 3 of this Part, the Practitioner will be issued a letter notifying 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 are conducting 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 X 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 reviewers' findings, conclusions and recommendations reported to the Executive Committee of the Medical Staff (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 and 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 Section 2 above) and/or interview witnesses, including the Practitioner, at their discretion.

g. The report of the comprehensive focused clinical care review will be made to the ECMS within 14 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 X 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 Medical Center Director.

5. Recommendations Following the Review:

a. The ECMS can make the following recommendations to the Medical Center Director based on the evidence gathered before, during and after the review:

   i. No action;

   ii. Initiation of a Focus Professional Practice Evaluation (FPPE);

   iii. Revocation of privileges; or

   iv. Reduction in privileges.

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

c. No action: If the Medical Center Director concurs with the ECMS's recommendation for no action, the Practitioner will be notified in writing within five calendar days and, if applicable, be notified that privileges are restored.

d. FPPE:

i. If the recommendation is for an FPPE to be initiated, privileges will be reinstated upon the creation and issuance of the FPPE. The FPPE 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 and demonstrate the requisite skill and knowledge in those areas of clinical issues identified as a concern. An FPPE will normally be for a minimum of 60-calendar days. In general, extension of the FPPE is discouraged.

ii. Upon completion of the FPPE, results will be reported back to the ECMS.

e. Revocation of Privileges:

i. If the ECMS recommends that the Practitioner's privileges be revoked, or if a Practitioner fails an FPPE 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 Practitioner to have clinical privileges.

ii. 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.

iii. 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 Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are 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.

iv. 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 Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are 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.

v. If the Practitioner is appointed through a contract, the contracting officer will be notified of the recommendation for revocation of clinical and privileges and need to remove the Practitioner from the facility. The Practitioner will be separated and subsequently be notified of the right to a fair hearing after separation in accordance with Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are 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. <u>Reduction of Privileges:</u>

i. 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.

ii. 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.

iii. 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 then 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 X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are 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.

iv. 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 a suspension, transfer of function, 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 Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the separation are 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.

v. 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 subsequently be notified of the right to a fair hearing after separation in accordance with Part X 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 Part X of the Bylaws. The fair hearing is limited to a determination as to whether or not the reason(s) for the

reduction are due to substandard care, professional misconduct, or professional incompetence, which would result in reporting to the NPDB.

6. Automatic Suspension of Privileges:

   a. An automatic suspension of privileges occurs immediately under the occurrence of an event that may include, but is not limited to, the following:

      i. The Practitioner is being investigated or was indicted for a misdemeanor or felony. The privileges may only be reinstated after the outcome of the legal issue is finalized and after a determination is made regarding the nexus between the legal issue and the mission of VA.

      ii. 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.

      iii. The Practitioner is being investigated for the fraudulent use of Government equipment or a Government-issued credit card.

      iv. The Practitioner fails to maintain the mandatory requirements for membership to the medical staff.

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

   c. The Medical Center Director may initiate an appropriate review of the concern(s) or issues(s) resulting in the automatic suspension to include recommendations for appropriate administrative action.

   d. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in 1 calendar year, a thorough assessment of the need for the Practitioner's services must be performed, documented in writing, and appropriate action taken.

7. 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 X or a Disciplinary Appeals Board (DAB) will not have arisen in any of the following circumstances:

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

b. The conduct of an investigation into a matter;

c. 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;

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

e. The imposition of proctoring or observation on a Medical Staff member, which does not restrict clinical privileges or the delivery of professional services to patients;

f. Corrective counseling;

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

h. Any recommendation or action not "adversely affecting" (as such term is defined in Section 431(1) of the Health Care Quality Improvement Act) any applicant or Practitioner, or which is not based on a subjective determination of the professional competency or conduct of the applicant or Practitioner.

ARTICLE X FAIR HEARING AND APPELLATE REVIEW *

Section 10.01 Reduction of Privileges

1. Reduction of Privileges: [In Accordance with VHA Handbook 1100.19]

a. Prior to any action or decision by the Medical Center 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:

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

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

a) 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.

b) Information will be forwarded to the Medical Center Director for decision. The Medical Center Director will make a decision on the basis of the record. If the Practitioner disagrees with the Medical Center 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 Medical Center Director.

c) A proposed action taken 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. 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.

2. Convening a Panel:

i. 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 in 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.

ii. 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 Medical Center 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 processes must be conducted on the basis of the record. The hearing will proceed as follows:

i. 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.

ii. 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. 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.

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

3. 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 Medical Center Director grants additional time due to extraordinary circumstances or cause.

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

b. The Medical Center 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 Medical Center Director constitutes a final action and the reduction is reportable to the NPDB.

c. If the Practitioner wishes to appeal the Medical Center Director's decision, the Practitioner may appeal to the appropriate VISN Director within 5 business days of receipt of the Medical Center Director's decision. This appeal option will <u>not</u> delay the submission of the NPDB report. If the Medical Center Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

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

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

4. The hearing panel chair shall do the following:

a. Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.

c. Maintain decorum throughout the hearing.

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

e. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.

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

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

5. 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 Medical Center 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, or resigns or retires from his/her medical staff position with the Department of Veterans Affairs while the Practitioner's professional competence or professional conduct is under investigation to avoid investigation, for greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

Section 10.02 Revocation of Privileges

6. Revocation of Privileges:

a. Proposed action taken to revoke a Practitioner's privileges will be made in accordance with VHA Handbook 1100.19, and the following regulations are applicable:

i) 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.

ii) 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 Medical Center 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. Refer to Article X, Section 10.01, para 2 for due process procedures.

iii) 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 all due process has been exhausted. Refer to Article X, Section 10.01, para 2 for due process procedures.

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, is 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 *<insert acronym for committee that serves as executive committee of the*

medical staff, such as MEC for Medical Executive Committee> for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X, section 10.01, para 2 of these Bylaws.

7. Reporting to the National Practitioner Data Bank[1]:
   a. Tort claims (claims field under the Federal Tort Claim Act) 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 filed so that they may assist Regional and General Counsel in defending the case and in decisions concerning denial or settlement.

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

   e. VA only reports adverse privileging actions that adversely affect the clinical privileges of 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 be reported.

8. <u>Reporting to State Licensing Boards</u>: VA has a responsibility to report to state licensing boards appointed or suspended members of the Medical Staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

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[1] Reference VHA Handbook 1100.17, Dec 2009, National Practitioner Data Bank Reports

9. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Medical Center 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.

ARTICLE XI RULES AND REGULATIONS *

1. As may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to identify the level of clinical practice that is required of each member of the Medical Staff and of all others with delineated clinical privileges or practicing under a Scope of Practice, Medical Staff Rules and Regulations may be adopted. Rules and Regulations may be adopted, amended, repealed or added by a majority vote of the members (as determined by the Facility) of the *<Insert name of committee that serves as executive committee of the medical staff>* present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. Medical Staff Rules and Regulations must be approved by the Medical Center Director.

ARTICLE XII AMENDMENTS *

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. The proposed changes or any changes to the rules and regulations and policies will be discussed in the Executive Committee of the Medical Staff (ECMS) and any recommendations for change will come directly from the ECMS. Proposed changes to the bylaws are reviewed, voted on and adopted by the organized Medical Staff as a whole and then approved by the Medical Center Director. The Bylaws are amended and adopted by endorsement of the active Medical Staff.
2. The Executive Committee of the Medical Staff may adopt urgent amendments to the Rules and Regulations that are deemed necessary for legal or regulatory compliance. After adoption, these urgent amendments to the Rules and

Regulations will be communicated back to the Organized Medical Staff for review through the clinical service via electronic communication. 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 III, Section 3.04 should be followed.

3. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
4. All changes to the Bylaws require action by both the Organized Medical Staff and Medical Center Director. Neither may unilaterally amend the Bylaws.
5. Changes are effective when approved by the Medical Center Director.

ARTICLE XIII ADOPTION *

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

If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy or an amendment thereto, they must first communicate the proposal to the Executive Committee of the Medical Staff (ECMS). The ECMS will review such proposed change(s), and, if in agreement, will recommend approval to the Governing body. If the ECMS wants to adopt a rule, regulation, policy or an amendment, it must first communicate such change(s) to the Organized Medical Staff.

RECOMMENDED

Ralph M. Schapira 3/14/2016

Ralph M. Schapira, MD Date

Chief of Staff

APPROVE

3-21-2016

Fernando O. Rivera, FACHE Date

SLVHCS Medical Center Director

MEDICAL STAFF RULES

1. GENERAL

A. The Rules relate to role and/or responsibility of members of the Medical Staff and individuals with clinical privileges in the care of any and all patients.

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

C. The Medical Staff as a whole shall hold meetings at least annually.

D. The Executive Committee of the Medical Staff serves as the executive committee of the Medical Staff and between the annual meetings, acts in their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out in the facility.

E. Each of the clinical Services shall conduct meetings monthly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by medical staff and responsible party of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.

F. Information used in quality improvement as referenced in Article IX, cannot be used when making adverse privileging decisions.

2. PATIENT RIGHTS *

A. Patient's Rights and Responsibilities: This Organization supports the rights of each patient and publishes policy and procedures to address rights including each of the following:

i) Reasonable response to requests and need for service within capacity, mission, laws and regulations.

ii) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.

iii) Collaboration with the physician in matters regarding personal health care.

iv) Pain management including assessment, treatment and education.

v) Information with regard to names and professional status of physicians and all other health care providers responsible for care, procedures, or treatments.

vi) Formulation of advance directives and appointment of surrogate to make health care decisions (38 CFR17.32).

vii) Access to information necessary to make care decisions that reflect patient's wishes, including potential outcomes, risks and benefits and consequences of refusal of treatment.

viii) Access to information about patient rights, handling of patient complaints.

ix) Participation of patient or patient's representative in consideration of ethical decisions regarding care.

x) Access to information regarding any human experimentation or research/education projects affecting their own care.

xi) Personal privacy and confidentiality of information.

xii) Action by a legally authorized person to exercise a patient's rights if a patient is judged incompetent in accordance with law or is found by a physician to be medically incapable of understanding treatment or unable to communicate his/her wishes.

xiii) Authority of Chief of Staff or his/her designee to approve/authorize necessary surgery, invasive procedure or other therapy for a patient who is incompetent to provide informed consent (when no next of kin is available).

xiv) Foregoing or withdrawing life-sustaining treatment including resuscitation.

xv) Nondiscrimination against individuals who use or abuse alcohol or other drugs and persons infected with the human immunodeficiency virus.

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

i) Patients with decisional capacity have the right to consent to and, equally, to decline any treatment including the provision of life-sustaining treatment. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the patient with decisional (decision-making) capacity consents or in emergent situations where informed consent may be implied. When the patient with decisional capacity withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.

ii) Medical decisions regarding the patient's diagnosis and prognosis, and treatment options to be presented to the patient, shall be made by the attending (staff) physician in consultation with, as appropriate, other members of the treatment team including house staff (38 USC sections 7331).

iii) With respect to the documentation of decision making concerning life-sustaining treatment, the following information, at a minimum, will be documented in the progress notes co-signed by the attending physician: The patient's diagnosis and prognosis; an assessment of the patient's decision making capacity; treatment options presented to the patient for consideration; the patient's decisions concerning life-sustaining treatment.

iv) Patients with decisional capacity will be encouraged, but not compelled, to involve family members in the decision making process. Patient requests that family members not be involved in or informed of decisions concerning life-sustaining treatment will be honored, and will be documented in the medical record.

v) Mental health service can assist with an assessment of a patient's decisional capacity.

vi) Advance Directives: The patient's right to direct the course of medical care is not extinguished by the loss of decision making capacity. In order that this right may be respected in cases involving such patients, VHA recognizes the right of an adult person to make an advance directive, in writing, concerning all treatment, including life-sustaining treatment. Any patient with decision-making capacity may execute a declaration requesting that some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the advance directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an advance directive may be revoked by a declarant at any time.

vii) Substituted Judgments: The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision making capacity or by the fact that an advance directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations. The person making decisions for a terminally ill patient who lacks decision making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending (staff) physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:

(a) Oral or written statements or directives rendered by the patient during periods when the patient had decision making capacity.

(b) Reactions voiced by the patient, when the patient had decision making capacity, concerning medical treatment administered to others.

(c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending (staff) physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the attending physician believes in good faith that the decision

of the surrogate decision maker is equivocal, does not reflect the patient's own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the attending physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to an Ethics Consultative Committee, or to the Chief of Staff.

3. RESPONSIBILITY FOR CARE*

A. Conduct of Care

i) Inpatient and outpatient management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff. **Residents are trainees who require supervision by the member of the medical staff to whom the resident is assigned. A resident must always have a clearly identified staff physician who is accessible and available at all times to the resident and consulting physicians as well as nursing staff. The staff physician must be able to care for a patient face-to-face with or without a resident and do so in the clinically-appropriate timeframe. All care provided by a resident are the responsibility of the assigned staff physician.** Medical staff should document in the medical record promptly after seeing a patient or rendering care and adhere to the required timeframes listed below. Attention to all items in the medical record, including timeliness of encounter completion and proper consultation completion are important aspects of the conduct of care. **It is a cardinal principle that responsibility for the care of each patient lies with the staff physician to whom the patient is assigned and who supervises all care rendered by residents.**

Access to CPRS: Every member of the paid Medical Staff must maintain access to the VA network and CPRS, including timely completion of mandatory training required for access to the VA network. In addition, remote access to CPRS is required for those Medical Staff that will be required to provide or supervise care from remote sites (i.e., supervising the care of a patient provided by a resident during off-tours or on-call).

(a) The Staff (attending) physician is responsible for the preparation and completion of a complete medical record for each patient, including the medical record entries of all those supervised by the staff physician. This record shall include a medical examination, an updated problem list, identification data, chief complaints, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathological findings, progress notes, doctor's discharge instructions sheet, including condition on discharge (discharge note) and final diagnosis, and final summary. The staff physician is responsible for knowing the results of consultations or requested studies, including

radiographic studies, laboratory tests, and biopsy results, and ensuring that the patient receives appropriate follow-up. The staff physician is responsible for assuring every inpatient is assigned to an appropriate level of care and that telemetry use meets the facility's requirements.

(b) The integrity of the medical record in terms of professionalism reflected in the notes and inappropriate use of **"copy and paste"** and other functionalities are the responsibility of the staff physician, including for those supervised by the staff physician. Inappropriately used, copy and paste leads to redundant, misleading, inaccurate and non-essential documentation that may jeopardize clinical care. See VHA Handbook 1907.01 March, 2015 (pages 26-28) and HIM Office of Informatics & Analytics, HIM Practice Brief # 9, Monitoring Copy & Paste, dated January 2013 for an explanation of the appropriate use of copy and paste and consequences for misusing copy and paste.

(c) A medical history and physical examination is completed within 30 days before admission or registration. The practitioner must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or an invasive procedure. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law, VHA regulations and hospital policy. The content of complete and focused history and physical examination is delineated in Section 3: Responsibility for Care, of the Medical Staff Rules and Regulations.

Medical Assessment of the patient shall include a Medical History that includes:

1. Chief complaint
2. Details of present illness
3. Relevant past, social and family history
4. Inventory by body system, including pain assessment
5. Summary of the patient's psychological needs
6. Report of relevant physical examinations
7. Statement on the conclusions or impressions drawn from the admission history and physical examination
8. Statement on the course of action planned for this episode of care and its periodic review
9. Clinical observations, including the results of therapy

(d) The attending (staff) physician responsible for the patient must sign the admission note if it is prepared by a resident, or Advanced Practice Professional, or make a note on the admission workup or progress notes to the effect that he/she "agrees with the admission workup and

findings" or make whatever comments he/she thinks the case warrants, or prepare a complete admission within forty eight (48) hours of admission to the Community Living Center. In the event a resident, intern, or Advanced Practice Professional prepares an admission workup, all will be retained, but the official workup will contain the responsible Medical Staff physician's approval signature. All resident documentation will follow procedures outlined in the VHA Handbook 1400.1, Resident Supervision and SLVHCS NM 00-3

(e) Food and nutrition products are administered only on the prescription or order of a Medical Staff member, an authorized house staff member, or other individual who has been granted authority to write such prescriptions or orders, within their scope of practice.

(f) Progress note entries should be identified as to the type of entry being made, (e.g., Resident Note, Attending Note, Off Service Note, etc.). The Attending Note must be signed by the Attending physician.

(g) Progress notes will be written at least once daily on all acutely ill patients. Progress notes are written for all patients seen for ambulatory care by the medical staff.

(h) Evidence of required supervision of all care by the attending physician shall be documented in the medical record, the frequency of notes dependent upon the severity of the illness of the patient. The identity of the responsible supervising staff physician must be included in each resident note.

(i) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written or countersigned by the attending physician in the patient's medical record. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility of the attending physician to ensure that the order and its meaning are discussed with appropriate members of the Facility staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.

(j) Patients will not be transferred out when the Facility has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer to a non-VA facility only after authorization is given by the Chief of Staff or his/her designee.

ii) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges, within and across Services and between all staff members who have clinical privileges.

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

B. Clinical Consultations: The Medical Staff, through its clinical Service Chiefs, will assure that appropriate clinical service consultations are requested. All consult requests must be entered into CPRS. Clinical service consultation is urged for the following situations: :

a) When the patient needs care that falls outside the scope of practice and clinical privileges of the physician in charge of the patient's care

b) When the patient is not a good risk for an operative procedures

c) When the diagnosis remains obscure after ordinary diagnostic procedures have been completed

d) When there are significant differences of opinion as to the best choice of therapy

e) In unusually complicated situations when specific skills of other practitioners may be helpful

f) When specifically required by the patient or family

i. A consultant will be a member of the Medical Staff designated by the pertinent Service Chief as well qualified to render an expert opinion in the field. A consultant must be well qualified to give an opinion in the field in which his/ her opinion is sought. The status of the consultant is determined by the Medical Staff and the Professional Standards Boards on the basis of an individual's training, experience, and competence. The Service Chiefs will make certain that members of their staff provide timely consultations as required and defined below.

ii. Consultation by the Medical Staff is available to veterans in all settings, including the emergency department, inpatient units and the Community Living Center (CLC), 24 hours per day, 7days a week. The staff physician is responsible to supervise all residents providing consultation to assure timeliness of consultation and appropriate supervision. The supervising staff physician must be identified in consultations provided by a resident.

iii. The urgency status of inpatient clinical consults is either "Stat" or "Routine." Stat will be defined as immediate need. Stat consults should be completed immediately or as clinically indicated. The sender of a Stat consult is required to:

a. Discuss and document the request with the intended receiver of the consult.
b. Enter "Today" in the EAD/CID field of the consult.
c. Enter "Stat" in the urgency field of the consult.

iv. Staff physicians are responsible to supervise residents and students who provide consultation as noted in SLVHCS NM 00-3. All consultation notes must document the involvement of the appropriate Medical Staff member on the consulting Service.

v. Essentials of a Consultation: A satisfactory consultation includes examination of the patient and review of the medical record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

vi. Psychiatric Consultations: Psychiatric consultation must be requested for all patients who attempt suicide or take a chemical overdose. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.

C. Discharge Planning: Discharge planning is initiated as early as a determination of need is made. The discharge planning process begins immediately upon admission.

i) Discharge planning provides for continuity of care to meet identified needs.

ii) Criteria for discharge are determined by the Multidisciplinary Treatment Team and discharge planning is documented in the medical record.

iii) Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.

D. Discharge

i) The staff (attending) physician shall lead the discharge process and guide residents in the process (if applicable). Patients shall be discharged from the Facility only upon the written order of the staff physician and the discharge summary will be completed (signed) and available for review in CPRS within 2 business days of discharge from the inpatient setting and 3 business days for Community Living Center (CLC) residents. At 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 record shall be completed within thirty (30) days of the discharge of the patient. The physician or dentist shall complete his/her portion of the record within thirty (30) days, including authentication.

ii) Patients from Ambulatory Surgery/Procedure Unit can be discharged based upon order of Licensed Independent Practitioner familiar with the patient or when the Practitioner is not available his/her designee.

iii) An unplanned discharge may occur when a competent patient chooses to terminate his/her hospitalization and refuses any further examination or

treatment that is medically indicated. The physician is responsible for informing the patient of the inherent clinical risks involved in the unplanned discharge, and the events/reason for leaving (if known) should be documented in the progress notes of the medical record. Future medical care will not be denied due to unplanned discharge.

E. Autopsy

i) Autopsy services are provided by Pathology and Laboratory Medicine Service. The availability of these services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. The autopsy is a significant instrument for continuous monitoring activity as part of the Performance Improvement Program within the Facility. See VHA Directive 2011-019, April, 2011, Autopsy as a critical component of quality management

ii) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17.170 Whenever possible, the physician responsible for the care of the patient at the time of death will be designated to request permission from the next of kin to perform an autopsy.

iii) Autopsy examination may be performed for medico-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.170, and VHA Handbook 1106.01

iv) Autopsy Rates. Autopsies are encouraged as per VHA policy.

v) Autopsy Criteria. VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Those cases meeting criteria as Coroner's cases per policy will be referred to the appropriate Coroner's Office in accordance with state statutes.

vi) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Coroner's Office, as do all cases in which death may be due to occupational causes.

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

4. INVESTIGATIONAL DRUGS

Investigational drug protocols must be approved by the SLVHCS Institutional Review Board (IRB) and the SLVHCS Research and Development Committee before an investigational drug can be administered at SLVHCS. All investigational drugs are approved by the P&T Committee, are to be supplied through the Pharmacy Service. Pharmacy Service will store, dispense and maintain accountability for the investigational drugs. For more details, see SLVHCS NM 119-1, Investigational Drugs for Patient Use, and VHA Handbook 1108.04, Investigational Drugs and Supplies, February 29, 2012.

5. PHYSICIANS' ORDERS *

A. General Requirements

i) Orders and prescriptions are entered into the electronic medical record (EMR).

ii) Telephone and verbal orders are discouraged except in patient care emergency or other urgent healthcare matters, or as outlined in a process designated by facility policy (SLVHCS NM 11-1). They will be accepted by clinical staff as designated by facility policy and when it clearly is in the best interest of patient care and efficiency.

B. Medication Orders

i) All drugs used in the Facility must be on the National Formulary and additions as approved by the VISN Pharmacy and Therapeutics (P&T) Committee or be Investigational Drugs that have been approved by the Research and Development Committee and the Facility P&T committee. Exceptions to the foregoing requirements may be made in use of "provisional drugs" or "non-formulary drugs" which can be issued under specific conditions. National criteria for non-formulary medications are developed by the National VA Medical Advisory Panel and/or at the VISN level. Exceptions are based on an individual patient case by case basis.

ii) All drugs used in the Facility will be stored and dispensed by the Pharmacy.

iii) Duration of Orders:

(a) Schedule II controlled drugs will be written for periods not to exceed fourteen (14) days for in-patients and must be reentered by electronic entry for each succeeding period of 14 days or less.

(b) Schedule III – V controlled drugs may be written for a period not to exceed thirty (30) days.

(c) Antibiotics orders must include the duration of the therapy.

(d) Orders for all other drugs will be written for a period not to exceed thirty (30) days from the date the first medication was ordered before they expire and must be rewritten.

iv) Ambulatory Care Medication Orders:

(a) All prescriptions must be entered electronically.

(b) All prescription for controlled substances will follow VHA Handbook 1108.01.

(c) Ninety (90) days is the maximum duration for applicable outpatient prescriptions and 30 days for controlled substances

(d) The number of refills authorized on a single prescription may not to exceed one year.

v) Transfer of Patients: When a patient is transferred from one level of care to another level of care, or there is a change in provider of record, orders must be written for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.

C. Standardized Order Sets (protocols): Standardized order sets are reviewed periodically by Section or Service Chief and modified as needed. All standardized order sets in the EMR/medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by medical staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief under the direction of the ACOS-Clinical Informatics.

D. Informed Consent:

i) Informed consent will be consistent with legal requirements and ethical standards, as described in Facility policy Informed Consent.

ii) Evidence of receipt of Informed consent, documented in the medical record, is necessary before procedures or treatment for which it is required.

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

F. Review of outside pathological material:

When patients are scheduled to undergo treatment (surgery, radiation or chemotherapy) based on biopsy samples obtained elsewhere, representative tissue material must be reviewed by a pathologist at this Health Care System and the diagnosis confirmed. The treatment/procedure should not be performed until confirmation of the diagnosis has been obtained by the treating physician. The treating physician should initiate the request that the material from the outside source be sent to SLVHCS for review.

G. Special Treatment Procedures:

i) DNR (Do Not Resuscitate) Overview

Do Not Resuscitate and Withholding/Withdrawal of Life Sustaining Treatment: The policy of the SLVHCS is to provide the highest quality medical care to its patients. The presumptive standard of care requires full resuscitative measures if cardiac arrest occurs. The only conditions that justify withholding full resuscitative measures are: a written DNR order, which includes orders presented in State Authorized Portable Orders (SAPO), known in the state of Louisiana as the Louisiana Physician's Orders for Scope of Treatment ("LaPOST"), or a licensed physician (who knows the patient and exercises sound medical judgment) giving an instruction not to institute resuscitation of a patient who has just experienced an arrest. For more details, see SLVHCS NM 11-18, "State Authorized

Portable Orders (SAPO) "Do Not Resuscitate (DNR), Do Not Attempt Resuscitation (DNAR) or Orders for Life Sustaining Treatment."

(a) Responsibilities for medical decisions regarding the patient's diagnosis or prognosis are shared by the medical treatment team and the patient (or surrogate as appropriate in situations where the patient is deemed without capacity or incompetent to make pertinent decisions). If, in spite of clear communication and thorough discussion amongst the patient (or legal health care power of attorney or health care next of kin when the patient is without capacity or is deemed legally incompetent) and treatment team, there is serious disagreement regarding the appropriateness of a DNR order or procedures for its implementation, then an Integrated Ethics Consultative Committee consultation is recommended. The Chief of Staff is responsible for facilitating final decisions with regard to this policy only if the disagreement cannot be resolved with the assistance of the Integrated Ethics Consultative Committee.

(b) If the patient is alert and understands the implications of his/her diagnosis and prognosis and has expressed the desire that a DNR order be written, he/she will be informed that entry of a DNR order may be preceded by discussions with the Attending (staff) Physician on the inpatient service, or with the patient's primary Provider in charge of his/her care, and if indicated, with mental health, social work, and/or nursing service staff. The patient will be advised that discussions with family members or significant others, if any, may be desirable prior to deciding whether a DNR order will be considered.

(c) In cases where the patient is comatose or otherwise does not have decision-making capacity, and the patient has not executed either a declaration under VHA Handbook 1004.02, Advance Health Care Planning, or a similar document under authority of State Law, a decision for entry of a DNR order shall be reached after consultation between the patient's legal health care power of attorney (or health care next of kin) and the Attending (staff) Physician on the inpatient service, or with the patient's primary Provider in charge of his/her care.

(d) After discussion with the patient, the Attending Physician must enter a DNR progress note or addend a DNR progress note, if originally entered by other than the attending, in the patient's Medical Record. A DNR progress note entered by a resident must be co-signed by the Attending Physician.

(e) After it has been determined that a DNR order is appropriate for a particular patient, the order must be written by the Attending Physician, using the Code Status order in CPRS.

ii) <u>Sedation/Analgesia</u>

Any non-anesthesiologist LIP administering moderate or deep sedation and anesthesia must be qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved,

either intentionally or unintentionally. To this end, it is the policy of SLVHCS that providers must be clinically privileged in order to administer moderate sedation. See VHA Directive 1073 (Dec 2014) and SLVHCS NM 112-13 "Moderate Sedation by Non-Anesthesia Providers" mandate requirements at the time of request for moderate sedation privileges.

iii) Emergency Commitment:

Inpatients who require a change of status from voluntary to involuntary admission: A patient may be detained as an involuntary patient for 72 hours if he/she is considered to be (1) a danger to others, (2) a danger to him/herself, or (3) gravely disabled (a condition in which a person is unable to provide for basic needs for food, clothing, or shelter). For more details, see SLVHCS NM 116-15 "Management of At-Risk, High Risk for Suicide, and Missing Patients."

6. ROLE OF ATTENDING STAFF *

A. Supervision of Residents and Non-Physicians

VHA Handbook 1400.01 Resident Supervision (Dec 2012) details the required supervision of physician, dentist, podiatrist, and optometrist residents and focuses on resident supervision from the educational perspective. The identity of the staff physician supervising the resident must be included in all progress notes and the supervising staff physician must be available and accessible to the resident and all other members of the health care team caring for the patient at all times. The staff physician must always be available to provide direct, face-to-face care of the veteran patient with or without a resident. The staff physician is responsible for the care of patient provided by a resident.

i) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities (SLVHCS NM 00-3 Resident Supervision and Monitoring of Resident Supervision). Residents are assigned to SLVHCS for the primary purpose of receiving education and training in their respective specialties. The ultimate responsibility for all patient care rests with the SLVHCS attending (staff) physician.

Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities. It is the responsibility of VA staff physicians involved in the residency training programs to ensure that the educational quality of these programs is maintained at a high level and that the patient care delivered by residents as part of their education and training is appropriate in content and of consistently high quality. Supervision of Resident(s) is not limited to that provided by staff Physicians. Other health providers provide feedback for residents about patient assessment and care. In the event a resident's order for patient care or assessment of a

patient's condition is questioned by another health professional, that professional is responsible for communicating the question to the resident's staff physician as well as the resident.

ii) In the outpatient setting, every patient who is new to the facility must be seen by or discussed with an attending physician.

ii) Medical staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone, except that this may result in loss of faculty appointment at the academic affiliate.

B. Documentation of Supervision of Resident Physicians

i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.01 Resident Supervision (Dec 2012).

ii) Entries in the medical record made by residents or by those non-physicians whose notes require countersigning by supervisory or attending medical staff members, are covered by appropriate Facility policy and include:

(a) Admission medical history and physical examination.

(b) Discharge Summary.

(c) Operative Reports.

(d) Medical orders that require co-signature.

(1) DNR

(2) Withdrawing or withholding life sustaining procedures.

(3) Certification of brain death.

(4) Research protocols.

(5) Investigational drug usage, ONLY permitted by named principal investigators or co-investigators previously designated in the study.

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

iii) Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels

of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising Practitioner (Attending physician) over and above standard setting-specific documentation requirements (VHA Handbook 1400.01, page 6).

C. Designated administrative staff will be authorized to make administrative entries as approved by the Chief of Staff. These administrative entries can be for the purposes of: (1) creating electronic forms for the inclusion into the computerized patient record system, (2) administratively closing open requests or orders, (3) entering administrative progress notes, (4) entering notes to disposition consultation requests and (5) completing other requirements as requested by the Chief of Staff or his/her designee.

7. MEDICAL RECORDS *

A. Basic Administrative Requirements:

i) Medical records are legal documents and are the property of the Medical Center; they are under the custody of Health Information Management Service (HIMS). SLVHCS NM 136-12, "Consolidated Health Records (CHRs)" details the primary components and management procedures for the medical record. "Medical records" refers to all VA medical record systems, not just those contained in CPRS.

ii) The integrity of the medical record in terms of professionalism reflected in the notes and inappropriate use of **"copy and paste"** and other functionalities are the responsibility of the staff physician, including for those supervised by the staff physician. Inappropriately used, copy and paste leads to redundant, misleading, inaccurate and non-essential documentation that may jeopardize clinical care. See VHA Handbook 1907.01 March, 2015 (pages 26-28) and HIM Office of Informatics & Analytics, HIM Practice Brief # 9, Monitoring Copy & Paste, dated January 2013.for an explanation of the appropriate use of copy and paste and consequences for misuse of copy and paste.

iii) Veterans should be encouraged to register with My Healthy Vet, VA's online personal health record, to access his/her health information.

iv) Medical records contain valuable and confidential information and are to be safeguarded again loss, tampering, or use by unauthorized persons. Nothing shall be maliciously removed, edited or deleted from a medical record, and no irrelevant notations may be made in them. Medical records must not be used as a vehicle to express concern regarding administrative or clinical issues that are not directly relevant to the ongoing care. Access to computerized records is controlled by assigning specific verify and access codes with specific menu options to appropriate staff.

v) The health record needs to reflect honest and candid statements; derogatory or critical comments are to be avoided. Individual employee

names are not to be included in health record documentation unless the purpose is to identify practitioners for continuing care.

vi) Questions concerning an amendment to the record will be referred to the Privacy Officer or designee for determination of proper procedures to follow. Amendments to the record, when approved by the provider, will be made by the Chief of Health Information Management Section (HIMS) or designee, if the individual making such request can show proof an error exists. (ref: SLVHCS NM 136-11, Safeguarding Medical Information

vii) Information may not be released from the medical record or copies made thereof except by designated individuals on the HIMS/Release of Information (ROI) staff. Release of information (ROI) is required as per policy (SLVHCS NM 136-2, Release of Information) and VHA Handbook 1605.1 Patient information may be released at the point of care only if relevant to the patient's clinical follow-up or treatment plan for that visit. Patient information may be released to outside agencies, such as the Department of Public Health, the Department of Motor Vehicles, or required registries. Those disclosures must be documented on a spread sheet and access given to HIMS Staff for accounting of disclosures. Patients' questions about the content of record should be referred to the primary care physician.

viii) All medical records are protected under the Federal Privacy Act of 1974. Any authorized user of the record automatically comes under the tenets of this law.

ix) Entries must be electronically entered where possible, which automatically dates, times, authenticates with method to identify author, may include written signatures.

x) It is the responsibility of the medical medicine staff to authenticate and, as appropriate, co-sign or authenticate notes by Advanced Practice Professionals (NP or PA) as part of the collaborative relationship. Physician involvement in patient care involving a NP or PA, including face-to-face care of the patient or involvement in decision-making without direct patient contact will be documented in the medical record.

xi) Final diagnosis and complications are recorded without use of abbreviations and symbols. A list of abbreviations not to use can be found in related Facility policy (SLVHCS NM 00E-4), and is available in CPRS and VISTA. Those abbreviations are not acceptable for use either handwritten or in the EMR.

xii) Completion and filing of reports of diagnostic and therapeutic procedures must be accomplished within 24 hours.

xiii) All medical records are confidential and the property of the Facility and shall not be removed from the premises without permission (ROI from the Patient/consultation with the privacy officer as appropriate). Medical records may be removed from the Facility's jurisdiction and safekeeping only in

accordance with a court order, subpoena, or statute. Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 U.S.C. 7332. .

xiv) All medical records must contain:

- Patient identification (name, address, DOB, next of kin).
- Medical history including history and details of present illness/injury.
- Observations, including results of therapy.
- Diagnostic and therapeutic orders.
- Reports of procedures, tests and their results.
- Progress notes.
- Consultation reports.
- Diagnostic impressions.
- Conclusions at termination of evaluation/treatment.
- Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in Facility Policy Memorandum "Informed Consent" (SLVHCS NM 11-7)
- Evidence of medication reconciliation in accordance with SLVHCS NM 11-5, "Medication Reconciliation."
- All notes must include the appropriate Provider name, credentials, and official organizational title in the electronic signature block in the format required.
- For the medical record, the attending (staff) Physician must have:

  (a) Written orders for all medications and other treatment.

  (b) Admission Note. The Admission Note may be prepared by a resident, intern, or Advanced Practice Professional. Resident documentation must follow procedures outlined in the VHA Handbook 1400.01, "Resident Supervision" and SLVHCS NM 00-3, "Resident Supervision and Monitoring of Resident Supervision."

  (c) For consultations, a consultation note, recorded in accordance with NM 136-13, "Consultation Management" and signed in the stipulated timeframe for consultation.

  (d) Ordered the minimum routine tests required by the clinical service. All tests and procedures performed on patients of the Medical Center shall be documented in the medical record.

(e) Documented all orders for the medical care and treatment of their patients.

(f) Countersigned verbal orders within 72 hours of the verbal order.

(g) Attending physicians may review and correct, if needed a discharge summary or operative report. If the electronic report is not authenticated the corrections may be made directly to the report. If the report is authenticated, an addendum is required.

(h) All new patients to a clinic setting or the facility must be seen by or discussed with the attending (staff) physician. New patients to a clinic setting or facility require an additional level of scrutiny that is above commonly accepted supervision standards. For documentation, an independent note, addendum to the resident's note, or resident note description of attending involvement is required. Co-signature of resident note by attending alone is not sufficient documentation.

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

- A history that includes chief complaint, history of present illnesses, childhood illnesses, adult illnesses, operations, injuries, medications, allergies, social history (including occupation, military history, and habits such as alcohol, tobacco, and drugs), family history, chief complaint, and review of systems;
- A complete physical examination includes (but not limited to) general appearance, review of body systems, nutritional status, ambulation, self-care, mentation, social, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient's history. Examination findings will be documented in the note. The note must be authenticated and signed by the Attending Physician at the earliest possible time, but not to exceed the end of the next calendar day after admission, including weekends and holidays, of being written in CPRS.

  (a) If the H&P was completed prior to the admission or procedure, it must be updated the day of admission. If it is more than 30 days old, a new one must be completed.

  (b) Inpatient H&P must be completed within 24 hours, 72 hours for Community Living Center (CLC); and 7 days for the Domiciliary
- A discharge plan (from any inpatient admission or Domiciliary), including condition on discharge.
- Discharge instructions should include medication list, pain management plan and follow-up appointments.
- A discharge summary signed (from inpatient or Domiciliary) and available for review in CPRS within 2 business days of discharge from the inpatient

setting and 3 business days for CLC residents. The record must be completed within 30 days of discharge. The physician or dentist shall complete his/her portion of the record within 30 days, including authentication.

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

i) A progress note for each visit, signed on the day of the visit. .

ii) Relevant history of illness or injury and physical findings including vital signs.

iii) Patient disposition and instruction for follow-up care.

iv) Immunization status, as appropriate.

v) Allergies.

vi) Referrals and communications to other providers.

vii) List of significant past and current diagnoses, conditions, procedures, drug allergies,

viii) Medication reconciliation, problem list, and any applicable procedure and operations.

D. Surgeries and Other Procedures:

i) All aspects of a surgical patient's care, including ambulatory surgery, pre-operative, operative and post-operative care, must be documented. Surgical interventions, diagnostic procedures, or other invasive procedures must be documented to the degree of specificity needed to support any associated coding data and to provide continuity of care.

ii) Preoperative Documentation:

(a) In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit, in cases of emergency surgery, the supervising (attending) or staff Practitioner must evaluate the patient and write a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed, with documentation up to 30-days pre-op, not to exceed the end of the next calendar day after admission, or the day before the OR procedure. Discussion and documentation of Informed Consent must be completed, with the patient and family of risks, benefits, potential complications; and alternatives to planned surgery and signed consent, as outlined in the facility policy (SLVHCS NM 11-7).

(b) Invasive procedures and surgeries involving local and/or moderate sedation require a focused history and physical or Subjective/ Objective/ Assessment/Plan (SOAP) note addressing pertinent positive/negative information, indications for the procedure, known

risks related to the procedure, and a physical examination pertinent to the procedure. A formal consultation to the service for performing the procedure that includes all required content will serve as an H&P if done w/in 30 days, but must be updated the day of the procedure.

(c) Except in an emergency, no patient may go to the operating room without a complete history and physical examination recorded in his/her chart plus recorded results of lab work and x-rays.

(d) A surgical operation shall be performed only with documented informed consent of the patient or his/her legal representative except in emergencies at which time the Chief of Staff or designee holds jurisdiction.

iii) Immediate Post-Operative Documentation: A post-operative progress note **must** be written, or directly entered into the patient's CPRS record, by the operating staff surgeon immediately following surgery and before the patient is transferred to the next level of care.

(a) The immediate post-operative note must include:

(1) Pre-operative diagnosis,

(2) Post-operative diagnosis,

(3) Technical procedures used,

(4) Estimated Blood loss,

(5) Supervising Staff (operative) and resident Surgeons,

(6) Presence and involvement of supervising staff surgeon

(7) Operating findings,

(8) Specimens removed, and

(9) Complications.

(b) The immediate post-operative note may include other data items, such as:

(1) Anesthesia,

(2) Blood loss

(3) Drains,

(4) Tourniquet Time, or

(5) Plan.

iv) Post-Operative Documentation: An operative report **must** be completed by the operating (staff) surgeon immediately following surgery. "Immediately" means upon completion of the operation or procedure, before the patient is transferred to the next level of care. The body of the report needs to contain the: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative diagnosis; names of the

supervising Practitioner, primary surgeon, and assistants; and the presence and/or involvement of the supervising Practitioner; whether or not the procedure was elective, urgent or emergent, whether a "time-Out' was performed, pre-op surgical site infection prophylaxis antibiotics were given, as well as the use of venous thromboembolism prophylaxis, as indicated, was used.

v) Post Anesthesia Care Unit (PACU) Documentation:

(a) PACU documentation must include the patient evaluation on admission to, and discharge from, the post-anesthesia care unit, a time-based record of vital signs and level of consciousness (either paper or electronic), all drugs administered and their doses, type and amounts of intravenous fluids administered, including blood and blood products, any unusual events including post-anesthesia or post-procedural complications, and post-anesthesia visits.

(b) The health record must document the name of the staff surgeon responsible for the patient's release from the recovery room, or clearly document the discharge criteria used to determine release.

(c) For inpatients, there needs to be at least one documented post-anesthesia visit after leaving the post-anesthesia care unit. The note needs to describe the presence or absence of anesthesia-related complications and the plan for subsequent pain management.

(d) For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery.

8. INFECTION CONTROL *

Hospital acquired infections (HAIs) are potential hazards to all persons having contact with a hospital. The goal of the Infection Control Program at SLVHCS is to provide a safe environment for all patients, visitors, and employees. The main elements of this program include adherence to the principles of hand hygiene, standard blood and body fluid precautions, surveillance, analysis of HAIs, prevention strategies, and staff education. It is the responsibility of all SLVHCS personnel to comply with the SLVHCS infection control policies and embrace an antimicrobial stewardship approach in optimizing treatment outcomes while minimizing antimicrobial-related adverse events, including the development of antimicrobial resistance (SLVHCS NM 00-114, 00E-00, 00E-1, 00E-3) and VHA Directive1031, January 22, 2014 Antimicrobial Stewardship programs.

C. Isolation precautions and procedures are described in Infection Prevention Policy – SLVHCS NM 00E-00

D. Standard Precautions are described in Infection Prevention Policy – SLVHCS NM 00E-00.

E. Reportable Cases are described in Infection Prevention Policy 00E-00.

9. CONTINUING EDUCATION *

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

10. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM *

A. The VHA recognizes its responsibility to assist impaired professionals and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for physicians and dentists. Local policy is described in SLVHCS NM 11-57, 002C-03, and 11-9.

B. It is the responsibility of the Chief of each service to determine whether the practice of a physician, dentist, and optometrist is impaired specifically due to chemical dependency, or to serious physical or mental illness.

C. The Chief will conduct the appropriate inquiry, in consultation with Human Resources staff, into whether the impairment of the practice of a physician, dentist or optometrist is specifically due to chemical dependency, or to serious physical or mental illness. This inquiry includes discussing the concerns with the individual and with his or her immediate supervisor.

D. In cases of known or suspected impairment due to mental illness or substance use, the Service Chief will follow established procedures as set forth in the Employee Assistance Program Policy (SLVHCS NM 11-57) and notify the Chief of Staff of the assessment.

E. Where there is evidence that a physician or dentist's practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff's office will be notified about the evidence.

F. In cases of known or suspected impairment due to physical and/or mental illness, the Chief of Staff may request the Medical Center Director to authorize a Special Physical Examination as authorized VA Handbook 5019, Part II, and applicable hospital policy. The Special Physical Examination will be tailored to the clinical circumstances and may involve a physical examination, imaging studies, neuropsychological testing, or other indicated measures. The fitness for duty examination will be conducted by or under the direction of the Occupational Health Program by an experienced MD level clinician or outside medical examiner, which will assess the findings and make a recommendation on the Practitioner's fitness for duty based on such findings. If the determination is

unfavorable to the Practitioner, or in cases of uncertainty, the findings will be presented to an ad hoc Physical Standards Board.

G. VA and Facility policies, responsibilities and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable for physicians, dentists, and other healthcare professionals.

H. Confidentiality of the Practitioner seeking referral or referred for assistance will be maintained, except as limited by law, ethical obligation, or when the safety of a patient is threatened. In all instances, every effort will be made to protect the confidentiality of the individual referred for assistance.

11. QUALITY MANAGEMENT SYSTEM and PEER REVIEW FOR QUALITY MANAGEMENT*

Medical Staff members shall participate in the facility protected peer review program established by the appropriate VHA policy (VHA Directive, Peer Review for Quality Management, 2010-025 and MCM, Peer Review for Quality Management, SLVHCS NM – 00E-8). All Medical Staff members will complete ongoing required training associated with VHA Peer Review policy. The Medical Staff must be involved in designing and deploying a comprehensive series of functions that support a culture of quality and safety in the facility, and the implementation of these integrated functions (See VHA Directive 1026,, 2013, VHA Enterprise Framework for Quality, Safety, and Value; SLVHCS NM 00E-11, 00E-11NB)

12. DISASTER AND NATIONAL EMERGENCIES

The VHA and SLVHCS will maintain sufficient capabilities to meet essential functions to serve veterans during a national, regional, or local emergency, including the capability to respond to the needs of individuals and State and local governments where required by law or binding Directive. SLVHCS will approach emergency response with a simultaneous and continuous two prong approach: to continue to maintain operational capability to provide services to veterans and serve as a national, regional, or local asset in times of emergency or disaster. Medical Staff have an inherent obligation to care for the sick and injured following national or man-made disasters, and national emergencies. All staff members should review their Services' role in the Medical Center Emergency Operations Plan, review their Service's Emergency Response Plans, and be familiar with their responsibilities during disaster drills or actual disasters. See VHA Directive 0320, April, 2012, Comprehensive Emergency Management Program and SLVHCS NM 00-32).

13. DISCLOSURE OF ADVERSE EVENTS TO PATIENTS

All Medical Staff members shall abide by the Facility disclosure policy in accordance with the appropriate VHA policy and document disclosures using the appropriate note titles as described in the Facility disclosure policy. See VHA Handbook

1004.08 October 2, 2012 DISCLOSURE OF ADVERSE EVENTS TO PATIENTS; and SLVHCS NM 00E-9 Disclosure of Adverse Events to Patients. The Chief of Staff is the only person who can make institutional disclosures on behalf of SLVHCS. Clinical Disclosure is an informal clinical process by which a member of the clinical care team informs the patient and/or the patient's personal representative, as part of routine clinical care, that a harmful or potentially harmful adverse event occurred during the patient's care. The disclosure discussion must be documented in the medical record if harm was more than minor. Institutional disclosure is a formal administrative process to review and disclose a reported serious adverse event that causes death or disability, leads to prolonged hospitalization, requires life-sustaining intervention, or is a "Sentinel Event" per The Joint Commission.

14. PART-TIME PHYSICIANS TIME AND ATTENDANCE REQUIREMENTS

VHA policy outlines requirements and processes governing part-time physicians' work hours including but not limited to work agreements, the establishment of tours, adjustable and fixed tours, record keeping and the annual reconciliation of hours worked. See VHA Directive 1035 November, 2013 OVERSIGHT AND IMPROVEMENT OF THE PART-TIME PHYSICIAN PROGRAM; and SLVHCS NM 05-2 Time and Attendance for Full and Part-Time Physicians, Dentists and Podiatrists.

15. CONTROLLED SUBSTANCES PRESCRIBING, OPIOID SAFETY INITIATIVE AND CHRONIC PAIN MANAGEMENT AND TREATMENT

It is the goal of the VHA to address issues of chronic pain management and treatment, including the appropriate use of opiates and non-opiate agents in chronic pain management. SLVHCS has embraced the VHA's Opioid Safety Initiative (OSI) and the pain management clinic resources to care for veterans. Each staff physician should review VA resources, such as the VA's Pain Management Opioid Safety VA Educational Guide (2014). Physicians, podiatrists, and dentists may apply for and be granted renewable certification by the Federal Drug Enforcement Administration to prescribe controlled substances as part of the SLVHCS practice. See VHA Directive 2009-053, October 28, 2009, Pain Management and SLVHCS NM 11-52 Pain Management, and 112-3 Opioid Analgesic Use for Chronic Non-Cancer pain

16. NON-VA MEDICAL CARE PROGRAM and the CHOICE ACT

On August 7, 2014, the President and Congress enacted the Veterans Access, Choice, and Accountability Act of 2014 ("Choice Act"). This act included a variety of ways to improve Veteran access to healthcare. The Medical staff of SLVHCS will request (through established mechanisms) that clinical services be provided outside

SLVHCS when SLVHCS cannot provide the care in the required time frame, or as directed by criteria of the Veterans Choice Program.

17. REQUIREMENTS FOR CPR TRAINING of STAFF (BLS AND ACLS)

All Medical Staff members shall abide by the Facility policy for Basic Life Support and Advanced Cardiac Life Support in accordance with the VHA Directive 1177, November 2014 CARDIOPULMONARY RESUSCITATION, BASIC LIFE SUPPORT, AND ADVANCED CARDIAC LIFE SUPPORT TRAINING FOR STAFF. See SLVHCS NM 002C-05 Basic Life Support and Advanced Cardiac Life Support.

Adopted by the Medical Staff, Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana, this 14th Day of March, 2016

RECOMMENDED

Ralph M. Schapira 3/14/16

Ralph M. Schapira, M.D. Date

Chief of Staff

APPROVE

3-21-2016

Fernando O. Rivera, FACHE Date

SLVHCS Medical Center Director