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VA SAN DIEGO HEALTHCARE SYSTEM



*A Division of VA Desert Pacific
Healthcare Network*

BYLAWS, RULES AND REGULATIONS
OF THE MEDICAL STAFF

2007

Revision History

8/1/2007: Article 12 revised to clarify the role of the Peer Review Committee in the confidential evaluation of practitioner professional performance and the processes followed when concerns are identified.

MEDICAL STAFF BYLAWS

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MEDICAL STAFF BYLAWS

Preamble

These Bylaws are adopted in recognition of the mutual accountability, interdependence, and responsibility of the Medical Staff and the Director of VA San Diego Healthcare System in protecting the quality of medical care provided in this health care system and assuring the competency of VASDHS's Medical Staff. The Bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Director for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Director, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and Services and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff officers; and they address the respective rights and responsibilities of the Medical Staff and the Director.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Director must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of VASDHS. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Director commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Director will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

DEFINITIONS

- 1) **Affiliation Partnership Council** - the committee established by Memorandum of Affiliation between the VA San Diego Healthcare System (VASDHS) and the University of California San Diego School of Medicine (UCSD-SOM) and approved by the Under Secretary for Health. It is composed of Deans, senior faculty members of the affiliate, representatives of the medical and dental staff of the facility, as well as the ACOS for Nursing, and other faculty of the affiliated medical school or other affiliated educational institutions. The VASDHS Director or Chief of Staff/Medical Director (Chief of Staff) and the Dean of UCSD SOM or Deputy Vice-Chancellor may co-chair this council. It is administratively supported by the Office of the Chief of Staff. The Council will consider and advise on development, management, and evaluation of all educational and research programs conducted at the facility. It is asked to advise on and endorse the appointments of Service Chiefs and members of the Medical Staff.
- 2) **Allied health professional/practitioner or AHP** - an individual, other than a licensed physician, dentist, clinical psychologist, optometrist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Director, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect patient care under the supervision or direction of a Medical Staff member possessing privileges to provide such care at VASDHS, and who may be eligible to exercise privileges and prerogatives in conformity with the policies adopted by the Medical Staff and Director, these Bylaws, and the Rules. AHPs are not eligible for Medical Staff membership. For the purposes of this document, AHP refers only to advanced practice nurses (e.g., Nurse Anesthetists, Nurse Practitioners, and Clinical Nurse Specialists) and Physician Assistants.
- 3) **Appointment** - for the purposes of this document, the 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 patient care services at the Medical Center and/or its Community Clinics. VA employees (with or without compensation), contractors, and fee providers may receive appointments to the Medical Staff.
- 4) **Director** - VASDHS Director or his or her designee.
- 5) **Chief of Staff** - VASDHS Medical Director and chair of the Medical Staff.
- 6) **Closed session of the Medical Executive Council** -
- 7) **Date of receipt** - the date any notice, special notice or other communication was delivered personally; or if such notice, special notice or communication was sent by mail, it shall mean 72 hours after the notice, special notice, or communication was deposited, postage prepaid, in the United States mail. *[See also, the definitions of notice and special notice.]*
- 8) **Days** - calendar days unless otherwise specified.
- 9) **Ex officio** - service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.
- 10) **Governing Body** refers to the Under Secretary for Health of the Veterans Health Affairs (VHA), the individual to whom the Secretary of Veterans Affairs has delegated authority for administration of the VHA. For the purposes of local facility management, Governing Body

may refer to the VASDHS Director. As appropriate to the context and consistent with VASDHS's policies, rules, and regulations, it may also mean any committee or individual authorized to act on behalf of the Director.

- 11) **Medical Executive Council** - the executive committee of the Medical Staff.
- 12) **Medical Record** - any information relating to the patient. This includes, but is not limited to, the inpatient and outpatient written record, radiograph reports, photographic studies, reports of special tests or pathology, and/or information stored on the Computerized Patient Record System (CPRS), Bar Code Medication Administration (BCMA) record, or other patient related databases of the VASDHS. Data concerning patients referred to VASDHS for care by other VA facilities is also available through the "Remote Data" function of CPRS and, therefore, part of the medical record.
- 13) **Medical Staff** - the organizational component of VASDHS that includes all physicians (M.D. or D.O.), dentists, clinical psychologists, optometrists, and podiatrists who have been granted recognition as members pursuant to these Bylaws.
- 14) **Member** - any practitioner who has been appointed to the Medical Staff.
- 15) **Notice** - a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or VASDHS. (*See also, the definitions of date of receipt and special notice.*)
- 16) **Physician** - an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.
- 17) **Practitioner/Provider** -, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, optometrist, podiatrist, or allied health professional.
- 18) **Primary Source** - the original source of a specific credential that can verify the accuracy of a qualification reported by an individual health care practitioner. Examples include medical school, graduate medical education program, and state medical board.
- 19) **Privileges or Clinical Privileges** - the permission granted to a Medical Staff member or AHP to render specific patient services.
- 20) **Professional Standards Board** - to the credentialing committee responsible for matters concerning the appointment, advancement, and probationary and for cause review of physicians, dentists, podiatrists, optometrists, and psychologists of the VASDHS. It reviews the initial privileges requested by each physician and makes recommendations to the Medical Executive Council and Director.
- 21) **Rules** - Medical Staff Rules adopted in accordance with these Bylaws unless specified otherwise. It does not refer to formally promulgated VHA or Department of Veterans Affairs (VA) rules or regulations.
- 22) **Special notice** - a notice sent by certified or registered mail, return receipt requested. (*See also, the definitions of date of receipt and notice above.*)
- 23) **Telemedicine** - the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.
- 24) **VASDHS** refers to the VA San Diego Healthcare System (VASDHS) main campus and Community Clinics (Mission Valley, Escondido, Vista, Chula Vista, Brawley, and Wellness

and Vocational Enrichment) organizationally aligned under Veterans Integrated Service Network (VISN) 22, Veterans Health Administration (VHA), and the Department of Veterans Affairs (VA).

- 25) **Verification** - the documentation of a specific source of primary education, training, licensure, or board certification either by letter, telephone, fax, computer printout, or listing in specific directories as provided in [VHA Handbook 1100.19 - Credentialing and Privileging](#) and supplements thereto.

ARTICLE 1

NAME AND PURPOSES

1.1 Name

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

1.2 Purposes and Responsibilities

1.2-1 The Medical Staff's purposes are:

- a. To assure that all patients admitted or treated in any of the VASDHS services receive a uniform standard of quality and timely patient care, treatment and efficiency consistent with generally accepted standards attainable within VASDHS's means and circumstances and subject to continuous performance review and improvement.
- b. To organize and support professional education and community health education and support services.
- c. To initiate and maintain rules for the Medical Staff to carry out its responsibilities for the professional work performed at VASDHS.
- d. To provide a means for the Medical Staff, Director, and administration to discuss issues of mutual concern and to implement education, research, and changes intended to continuously improve the quality of patient care.
- e. To establish and ensure adherence to an ethical standard of professional practice and conduct.
- f. To provide for accountability of the Medical Staff to the Director.
- g. To exercise its rights and responsibilities in a manner that does not jeopardize VASDHS's license, provider status, or accreditation.

1.2-2 The Medical Staff's responsibilities are:

- a. To provide quality patient care;
- b. To account to the Director for the quality of patient care provided by all members authorized to practice at VASDHS through the following measures:
 - 1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;
 - 2) An organizational structure and mechanism that allow on-going monitoring of patient care practices;
 - 3) A credentials program, including mechanism of appointment, reappointment, and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;

- 4) A continuing education program based at least in part on needs demonstrated through the medical care evaluation program;
 - 5) A utilization review program to provide for the appropriate use of all medical services;
- c. To recommend to the Director action with respect to appointments, reappointments, staff category and Service assignments, clinical privileges and corrective action;
 - d. To establish and enforce, subject to the Director approval, professional standards related to the delivery of health care within VASDHS;
 - e. To account to the Director for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities;
 - f. To initiate and pursue corrective action with respect to members where warranted;
 - g. To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts;
 - h. To establish and amend from time to time, as needed, Medical Staff Bylaws, Rules, and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws;

References:

[VHA Manual M1, Part 1, Chapter 26](#)

ARTICLE 2

MEDICAL STAFF MEMBERSHIP

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff and/or privileges may be extended to and maintained by only those professionally competent practitioners who continuously meet the qualifications, standards, and requirements of the VA, VHA, VASDHS, and as set forth in these Bylaws and the Rules. A practitioner, including one who has a contract with VASDHS to provide medical or administrative services, may admit or provide services to patients at VASDHS only if the practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with these Bylaws and the Rules. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been established by the Medical Staff and granted by the Director in accordance with these Bylaws.

2.2 Qualifications for Membership

2.1-1 General Qualifications

Medical Staff membership (except Education/Honorary/Retired Medical Staff) shall be limited to practitioners who are currently licensed to practice medicine, podiatry, clinical psychology, optometry, or dentistry, including full-time, part-time, intermittent, consultant, attending, without compensation, contract, fee, or practitioners employed in any other manner. Consultant physicians, whether with or without compensation, fee basis, contract and other physicians, dentists, podiatrists, optometrists, and psychologists shall have the same responsibilities as full-time or part-time paid medical staff members but may have a more limited degree of involvement in service on VASDHS committees.

2.1-2 Basic Qualifications

A practitioner must demonstrate compliance with all the basic standards set forth in this Section 2.2-2 in order to have an application for Medical Staff membership accepted for review. The practitioner must have:

- a. An active, current, full, and unrestricted license to practice the individual's profession in a state, territory, or commonwealth of the United States or the District of Columbia, as required by DVA employment, contracting, and utilization policies and procedures. For practitioners applying for a Telemedicine appointment, a valid California state license is required.
- b. Education applicable to individual Medical Staff member, i.e., hold a degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Optometry, or Doctor of Podiatric Medicine from an approved college or university.
- c. English language proficiency.
- d. Professional liability insurance or equivalent coverage as required by federal and VHA regulations, if providing services under contract.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the Education/Honorary/Retired Medical Staff category do not need to comply with any of the basic standards. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards which adversely affected such practitioner. The Medical Executive Council and the Director, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.1-4, Waiver of Qualifications, shall review those comments and requests.

2.1-3 Additional Qualifications for Membership

In addition to meeting the basic standards, the practitioner must:

- a. Document his or her:
 - 1) Adequate experience, education, and training consistent with professional assignment and requested privileges, including internships, residencies, fellowships, postgraduate or specialty training, as confirmed by relevant Board or other certification;
 - 2) Current professional competence validated through peer and/or employer references;
 - 3) Good judgment and professional conduct; and
 - 4) Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care for this community; and
- b. Be determined to:
 - 1) Adhere to the lawful ethics of his or her profession;
 - 2) Be able to work cooperatively with others at VASDHS setting so as not to adversely affect patient care or hospital operations; and
 - 3) Be willing to participate in and properly discharge Medical Staff responsibilities.

2.1-4 Waiver of Qualifications

Insofar as is consistent with applicable laws, the Director has the discretion to deem a practitioner to have satisfied a qualification, after consulting with the Medical Executive Council, if it is determined that the practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of VASDHS. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

2.2 Effect of Other Affiliations

No practitioner shall be entitled to Medical Staff membership merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he or she had, or presently has, staff membership or privileges at another health care facility.

2.3 Nondiscrimination

Medical Staff membership or particular privileges shall not be denied on the basis of age, sex, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or Rules of the Medical Staff or VASDHS.

2.4 Administrative and Contract Practitioners

2.4-1 Contractors with No Clinical Duties

A practitioner employed by or contracting with VASDHS in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of VASDHS and to the terms of his or her contract or other conditions of employment and need not be a member of the Medical Staff.

2.4-2 Contractors Who Have Clinical Duties

- a. A practitioner with whom VASDHS contracts to provide services which involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws. Unless a written contract or agreement executed after this provision is adopted specifically provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing, and appeal procedures of Article 13, Hearings and Appellate Reviews, of these Bylaws, upon termination or expiration of such practitioner's contract or agreement with VASDHS.
- b. Contracts between practitioners and VASDHS shall prevail over these Bylaws and the Rules, except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the state medical board and/or the National Practitioner Data Bank.

2.4-3 Subcontractors

Practitioners who subcontract with entities who contract with VASDHS may lose any privileges granted pursuant to an exclusive or semi-exclusive arrangement (but not their medical staff membership) if their relationship with the contracting entity is terminated, or VASDHS and the contracting entity's agreement or exclusive relationship is terminated. VASDHS may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right.

2.5 Basic Responsibilities of Medical Staff Membership

Except for Education/Honorary/Retired Medical Staff ([see Rule 1, Appendix 1B](#)), each Medical Staff member and each practitioner exercising temporary privileges shall continuously meet all of the following responsibilities:

- 2.5-1 Provide his or her patients with continuous care of the generally recognized professional level of quality and efficiency within the scope of privileges granted;
- 2.5-2 Observe Patients' Rights as delineated in [MCM 00-18 - Patient Rights and Responsibilities](#) and these Bylaws, in all patient care activities;
- 2.5-3 Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies and rules of the Medical Staff, VASDHS, VA and VHA;
- 2.5-4 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of the JCAHO, including conflict of interest statutes, (18 U.S.C. 202-209, 216), regulations, (5 C.F.R. Part 2635), and Executive Orders (12674, 12731), designed to ensure that federal employees act in the best interests of their employer;
- 2.5-5 Act in a manner that is consistent with the best interests of the organization, the taxpayers, and the patients;
- 2.5-6 Abide by the ethical principles of his or her profession and maintain standards of ethics, ethical relationships, and business integrity;
- 2.5-7 Discharge such Medical Staff, Service, Section, and committee functions for which he or she is responsible;
- 2.5-8 Assure the completion of a physical examination and medical history on all acute care inpatients, no more than 30 days before or 24 hours after admission.
- 2.5-9 Prepare and complete in timely and accurate manner the medical and other required records for all patients to whom the practitioner in any way provides services at VASDHS;
- 2.5-10 Refrain from unlawful inducements or conflicts of interest relating to patient referral.
- 2.5-11 Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's age, sex, religion, race, creed, color, national origin, or health status;
- 2.5-12 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised;
- 2.5-13 Coordinate individual patients' care, treatment, and services with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever

warranted by the patient's condition or when required by the rules or policies and procedures of the Medical Staff or applicable Service;

- 2.5-14 Actively participate in and regularly cooperate with the Medical Staff in assisting VASDHS to fulfill its obligations related to patient care, including, but not limited to, continuous quality and performance improvement, peer review, utilization management, quality evaluation, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time;
- 2.5-15 Recognize the importance of communicating with appropriate Service supervisors and/or Chief of Staff when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter;
- 2.5-16 Complete continuing medical education (CME) that meets all licensing requirements and is appropriate to the practitioner's specialty;
- 2.5-17 Adhere to the Medical Staff Standards of Conduct (as further described in Section 2.6), so as not to adversely affect patient care or hospital operations;
- 2.5-18 Participate in patient and family education activities, as determined by the Service or Medical Staff Rules, or the Medical Executive Council.
- 2.5-19 Notify the Medical Staff office in writing promptly, and no later than 30 calendar days, following any action taken regarding the member's license, DEA registration, privileges at other facilities, any challenge or claim against professional credentials, professional competence, or professional conduct, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action that could affect his/her Medical Staff standing, clinical privileges at VASDHS.
- 2.5-20 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Council.
- 2.5-21 Discharge such other employee obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Council.

2.6 Standards of Conduct

Members of the Medical Staff are expected to adhere to the Medical Staff Standards of conduct, including but not limited to the following:

- 2.6-1 General
 - a. It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interactions and behavior. The Medical Staff is committed to

supporting a culture and environment that values integrity, honesty, and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees, and visitors.

- b. Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and VASDHS may be found to be disruptive behavior. It is specifically recognized that patient care and Hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interactions at any level of VASDHS, in that all personnel play an important part in the ultimate mission of delivering quality patient care.
- c. In assessing whether particular circumstances in fact are affecting quality patient care or Hospital operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces—in addition to medical outcome—matters such as timeliness and appropriateness of services, timely and thorough communications with patients, and their families, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

2.6-2 Conduct Guidelines

- a. Upon receiving Medical Staff membership and privileges at VASDHS, the member enters a common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.
- b. Members of the Medical Staff are expected to behave in a professional manner at all times and with all people—patients, professional peers, Hospital staff, visitors, and others in and affiliated with VASDHS.
- c. Interactions with all persons shall be conducted with courtesy, respect, civility, and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with VASDHS.
- d. Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official channels.
- e. Cooperation and adherence to the reasonable rules of VASDHS and the Medical Staff are required.
- f. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral, or behavioral.

2.6-3 Adoption of Rules

The Medical Executive Council may promulgate rules further illustrating and implementing the purposes of this Section including, but not limited to, procedures for investigating and addressing incidents of perceived misconduct, and progressive remedial measures, including, when necessary, disciplinary action.

References:

VHA Handbook 1100.19 - Credentialing and Privileging

VHA Directive 2001-001 - Board Certification Requirement for Employment of Physicians

VHA Manual M-1, Part 1, Chapter 26 (change 101), Hospital Accreditation

VASDHS MCM 00-18 - Patient Rights and Responsibilities

5 CFR 2635, Standards of Ethical Conduct for Employees of the Executive Branch

VHA Handbook 1660.3, Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services, Enhanced Use Leases, Health Care Resource Sharing, Fee Basis and Intergovernmental Personnel Act Agreements (IPAs)

ARTICLE 3

CATEGORIES OF THE MEDICAL STAFF

3.1 Categories

Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in the Rules (see Rule 1). The members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the Rules. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges.

ARTICLE 4

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 General

- 4.1-1 The Medical Staff shall consider each application for appointment, reappointment, and privileges, and each request for modification of Medical Staff category using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and the Rules. The Medical Staff shall perform this function also for practitioners who seek temporary privileges and for AHPs. The Medical Staff shall investigate each applicant before recommending action to the Director, and the Director shall ultimately be responsible for granting membership and privileges (provided, however, that these functions may be delegated to the Chief of Staff with respect to requests for temporary privileges).
- 4.1-2 By applying to the Medical Staff for appointment or reappointment (or by accepting honorary Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will be subject to a full credentials review by the Professional Standards Board, Medical Executive Council, Director, and Affiliations Partnership Council:
- a. At the time of initial appointment to the Medical Staff, or
 - b. After a break in service of more than 15 days, except for approved extended medical, military, or educational/sabbatical leave.
 - c. Should the Medical Staff member be on extended leave, as noted above, at the time the two-year reappointment/reprivileging cycle ends, the organization may implement one of the following actions, depending on timing and circumstances:
 - 1) Reappoint/reprivilege the practitioner prior to the start of the leave of absence;
 - 2) Allow appointment to lapse and grant temporary privileges upon the practitioner's return for up to 45 days while the Medical Staff office processes a new appointment;
 - 3) Reappoint/reprivilege the practitioner during the leave of absence based on information gathered to-date, on the condition that the practitioner submit evidence of his or her ability to perform the privileges granted upon the practitioner's return.
 - d. In no case shall the organization extend the reappointment or privileges beyond the two-year cycle, or suspend and reinstate the reappointment and privileges for the unused term after the two-year date has expired.
 - e. These actions shall only be implemented in the event of an extended leave of absence, planned or unplanned, and may not be used when the two-year cycle cannot be met for other reasons.

- 4.1-3 Subsequent to Professional Standards Board review and Medical Executive Council approval and recommendation, initial clinical privileges may be granted by the Director, pending Affiliation Partnership Council review and approval, for a period of no more than two years.
- 4.1-4 Appointments to the Medical Staff occur in conjunction with VA employment, a VA contract or sharing agreement, or appointment without compensation. The authority for these actions is based upon:
 - a. Provisions of 38 United States Code (USC) in accordance with the appropriate VA Directives and supplements thereto, [VHA Handbook 1100.19](#) and supplements thereto, and the applicable Agreement(s) of Affiliation in force at the time of appointment;
 - b. Federal law authorizing VHA to contract for health care services.
- 4.1-5 Probationary periods apply to initial and certain other appointments made under 38 USC 7401 (1), 7401(3), and, where applicable, 5 USC 3301. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VHA policies and procedures. If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Clinical Service Chiefs, supervisors, and managers will similarly evaluate individuals employed under the provisions of 38 USC 7405 and those utilized under contracts and sharing agreements.

4.2 Applicant's Burden

- 4.2-1 An applicant for appointment, reappointment, advancement, transfer, and/or privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. The information must be complete and verifiable. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request or, if found after appointment, grounds for dismissal. Failure to comply in a timely manner with VASDHS mandatory training and certifications or to provide evidence of sufficient appropriate CME/CEU may result in suspension of pay and/or privileges or termination of appointment if not for pay. This burden may include submission to a physical or mental health examination as determined by the Medical Executive Council.
- 4.2-2 Any committee or individual charged under these Bylaws with responsibility of reviewing the appointment or reappointment application and/or request for clinical privileges may request further documentation or clarification. If the practitioner or member fails to respond within 30 days, the application or request shall be deemed withdrawn, and processing of the application or request will be discontinued. Unless the circumstances are such that a report to the state medical board is required, such a withdrawal shall not give rise to hearing and appeal rights pursuant to [Article 13, Hearings and Appellate Reviews](#).

4.3 Application for Initial Appointment and Reappointment

4.3-1 Application Form

A practitioner applying for appointment or reappointment is required to submit, on forms approved by VASDHS, an application for employment and a signed release of information that allows inquiry into issues pertinent to the applicant's qualifications and credentials. Applicants for membership to the Medical Staff are also required to submit professional credentials information electronically through the federal credentialing program, VetPro. Applicant will be required to agree to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. Applicant may also be required to certify receipt and understanding of certain Hospital, VHA, or VA rules or directives that apply to Medical Staff members. All information is subject to primary source verification and required clearances before credentialing is considered complete. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws and Rules. Following its investigation, the Medical Executive Council shall recommend to the Director whether to appoint, reappoint, or grant specific privileges.

4.3-2 Evaluation and Maintenance of Credentials

- a. Efforts will be made to verify, through primary sources, all credentials and employment claimed. A good faith effort to verify credentials is defined as an initial request and, if no response, one follow-up request within 30 days. All institutions where an individual received professional education; where residences, fellowships, and other training was performed; and where professional employment took place during the last five years (minimum), will be contacted. Verification may be either telephonic or written.
- b. A credentialing and privileging record (C & P folder) will be established and maintained for each practitioner requesting privileges. All folders (electronic and hard copy) will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging. At any time that a folder is found to lack required documentation for any reason, an effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the folder stating the reason. The entry will also detail the effort made to obtain the information, the date, and the signature of the individual responsible for the effort.

4.3-3 Medical Staff Member Obligations

Prior to the granting of an appointment or reappointment, Medical Staff members and AHPs will receive a copy of, or a web link to, the most current Bylaws and Rules, and agree to abide by the professional obligations as well as the VA employee obligations specified at the time of appointment or reappointment (e.g., annual mandatory training and certifications).

4.3-4 Basis for Appointment

- a. Except as next provided with respect to telemedicine practitioners, recommendations for appointment to the Medical Staff and for granting of

privileges shall be based upon the practitioner's training, experience, and professional performance at this hospital, if applicable, and in other settings, whether the practitioner meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon VASDHS's patient care needs and ability to provide adequate support services and facilities for the practitioner.

- b. Names and addresses of a minimum of three individuals qualified to provide authoritative reference information regarding training and experience, competence, health status, and/or fulfillment of obligations as a medical staff member within the privileges requested. The current or most recent employer(s) or institution(s) where clinical privileges are/were held must provide at least one reference. In the case of individuals just completing residency or fellowship programs, one reference must be from their Program Director.
- c. U.S. Citizenship. 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 if current visa status and documentation from the Immigration and Naturalization Service or employment authorization can be provided, pursuant to qualifications as outlined in 38 USC7405 and appropriate VHA Handbooks and Directives.
- d. The initial appointment of practitioners to the Telemedicine Staff may be based upon
 - 1) The practitioner's full compliance with this hospital's credentialing and privileging standards;
 - 2) or, using this hospital's standards, reliance in whole or in part on information provided by the hospital(s) at which the practitioner routinely practices;
 - 3) or, if the hospital where the practitioner routinely practices is JCAHO-accredited and agrees to provide a comprehensive report of the practitioner's qualifications, reliance entirely on the credentialing and privileging of that other hospital.

4.3-5 Basis for Reappointment

Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's performance at this hospital and in other settings. The reappraisal is to include confirmation of adherence to Medical Staff membership requirements as stated in these Bylaws, the Medical Staff Rules, and Hospital, VA, or VHA policies and directives. Such reappraisal should also include relevant provider-specific information, in aggregate, about performance, judgment, and clinical or technical skills. Where applicable, the results of 38 USC 5705 protected provider-specific peer review activities will act as a trigger for initiating a more thorough, non-protected review, the results of which may be used in the reappointment process. If sufficient review data are unavailable, peer recommendations may be used instead; or in the case of reappointment of a member of the Telemedicine Staff, reappointment may be based upon information provided by the hospital(s) where the practitioner routinely practices.

- 4.3-6 Failure to File Reappointment Application
Failure without good cause to timely file a completed application for reappointment shall result in the automatic termination of the member's privileges and prerogatives at the end of the current Medical Staff appointment. If the member fails to submit a completed application for reappointment within the time specified in the Rules, the practitioner shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the practitioner shall not be entitled to any hearing or review.

4.4 Approval Process for Initial Appointments

- 4.4-1 Recommendations and Approvals
The Service Chief shall review applications, engage in further consideration if appropriate as described in the Rules, and make a recommendation to the Professional Standards Board regarding staff appointments and clinical privileges. The Professional Standards Board shall then review the application and make a recommendation to the Medical Executive Council. The Medical Executive Council shall make a recommendation to the Director that is either favorable, adverse or defers the recommendation.
- 4.4-2 The Director's Action
The Director shall review any favorable recommendation from the Medical Executive Council and take action within 45 days by adopting, rejecting, modifying or sending the recommendation back for further consideration. After notice, the Director may also take action on his or her own initiative if the Medical Executive Council does not give the Director a recommendation in the required time. The Director may also receive and take action on a recommendation following procedural rights allowed at Article 13, Hearings and Appellate Reviews.
- 4.4-3 Final Action
If the parties are unable to resolve the dispute the Director shall make a final determination giving great weight to the actions and recommendations of the Medical Executive Council. Further, the Director's determination shall not be arbitrary or capricious, and shall be in keeping with his or her legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of VASDHS.
- 4.4-4 Expedited Review
The Director may use an expedited process for appointment, reappointment, or when granting privileges when criteria for that process are met, as further described in the Rules.
- 4.4-5 Notice of Final Decision
The Director shall give notice of final decision to the Medical Staff Office, which will notify the appropriate Service Chief and the applicant.

4.5 Approval Process for Reappointments

- 4.5-1 Recommendations and Approvals
The Service Chief shall review applications, engage in further consideration if

appropriate, as further described in the Rules, and make a recommendation to the Professional Standards Board regarding staff reappointment applications. The Professional Standards Board shall then review the application and make a recommendation to the Medical Executive Council. The Medical Executive Council shall review the Service Chief and Professional Standards Board's recommendations and all other relevant information available to it and shall forward to the Director its favorable recommendations, which are prepared in accordance with Section 4.4-2 above and the Rules.

4.5-2 Basis for Reappointment

Reappointment recommendations (including privilege recommendations) shall be based upon whether the member has met all of the qualifications and carried out all of the responsibilities set forth in the Medical Staff and Hospital Bylaws, Rules and Policies.

4.6 Leave of Absence

Members may request a leave of absence, which must be approved by the Medical Executive Council and cannot exceed two years. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in Section 4.1-2 and the Rules for reappointment review. The member must provide information regarding his or her professional activities during the leave of absence. During the period of the leave, the member shall not exercise privileges at VASDHS, and membership rights and responsibilities shall be inactive.

4.7 Confidentiality; Impartiality

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants in the credentialing process shall limit their discussion of the matters involved to the formal avenues provided in the Bylaws and Rules for processing applications for appointment and reappointment.

References:

VASDHS MCM 11-38, Credentialing Physicians, Advanced-Level Practitioners in the Event of a Disaster
VASDHS MCM 11- 56 Credentialing and Privileging/Scope of Practice
VHA Handbook 1100.19 - Credentialing and Privileging
VHA Directive 2003-014, VHA Requirement to Query the Federation of State Medical Boards.

ARTICLE 5

PRIVILEGES

5.1 Exercise of Privileges

Specific clinical privileges will be granted to each member of the Medical Staff by the Director, provided all other criteria in these Bylaws are met, for a period of no more than two years. Except as otherwise provided in these Bylaws or the Rules, every practitioner or allied health professional (AHP) providing direct clinical services at this hospital shall be entitled to exercise only those setting-specific privileges granted to him or her. Practitioners who wish to participate in the delivery of telemedicine services (whether to patients of this hospital, or to patients of another facility that this hospital is assisting via telemedicine technology) must apply for and be granted setting and procedure-specific telemedicine privileges. (Additionally, practitioners who are not otherwise members of this hospital's Medical Staff must apply for and be granted membership and privileges as part of the telemedicine staff (per [Rule 1](#), Appendix 1C) in order to provide services to patients of this hospital.) If clinical privileges are contingent upon appointment to the faculty of an affiliated institution, loss of faculty status will result in termination of the privileges specifically tied to the faculty appointment.

5.2 Criteria for Privileges

Subject to the approval of the Medical Executive Council and Director, each Service will be responsible for developing criteria for granting setting-specific privileges (including but not limited to identifying and developing criteria for any privileges that may be appropriately performed via telemedicine). These criteria shall assure uniform quality of patient care, treatment, and services. Insofar as is feasible, affected categories of AHPs shall participate in developing the criteria for privileges to be exercised by AHPs. Such criteria shall be consistent with the Medical Staff Bylaws, Rules or policies, or Hospital, VA, or VHA policies and directives. Exercise of clinical privileges within any Service is subject to the rules of the Service and the authority of the Service Chief. Practitioners with clinical privileges are assigned to and have clinical privileges in one clinical department/service. They may be granted clinical privileges in another clinical department/service if approved by the Service Chief.

5.3 Delineation of Privileges in General

5.3-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. All practitioner applications for clinical privileges must be made in writing and include all the privileges requested in the specialty and/or sub-specialty for which privileges are requested, in a format which has been approved by the Medical Staff, or by the Medical Executive Council acting on behalf of the Medical Staff. The privilege format may include categories or levels of care, or may list specific care activities, or may be a combination of both.

5.3-2 Basis for Privilege Determinations

- a. Requests for privileges shall be evaluated on the basis of the applicant's license, education, training, experience, demonstrated professional competence, judgment and clinical performance, (as confirmed by peers knowledgeable of the applicant's professional performance), health status, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the applicant's skills and knowledge, completion of employment obligations (e.g., annual mandatory training and certifications), and compliance with any specific criteria applicable to the privileges. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant exercises privileges.
- b. The Service Chief, to whose service the applicant for clinical privileges is assigned, is responsible for assessing all information and recommending to the Medical Executive Council action concerning the clinical privileges. In the case of initial privileges, the recommendation by the Service Chief will be based on the determination that the applicant meets the criteria for employment and for specific clinical privileges in the service, including requirements regarding education, training, experience, references, and health status.
- c. The Medical Executive Council, upon Service Chief recommendation, renews and recommends action on the clinical privileges based on each applicant's fulfillment of the requirements for clinical privileges as specified in these Bylaws.
- d. Initial clinical privileges are acted upon by the Director and granted within 60 days of receipt of a fully completed application for clinical privileges that includes all requirements previously set forth.
- e. The original signed clinical privilege document indicating privileges granted will be placed in the practitioner's Credentialing and Privileging folder. Copies will be distributed to the practitioner. [MCM 11-65, "Setting Specific Privileges and Performance of Procedures,"](#) governs the location where each privilege may be performed in the facility and its community clinics. Specific areas, such as the operating room, urgent care clinic, intensive care units, interventional radiology suite, and other appropriate sites have access to current privileging information so that appropriate staff in those areas may determine if a practitioner is privileged to practice or undertake specific operative or other invasive procedures which might be conducted in such areas. This information is housed in an electronic folder entitled "Nursing" available on every VASDHS computer desktop. Contents are easily searchable by provider name.

5.3-3 Amendment to Current Privileges

- a. If a member of the Medical Staff wishes to request amendment to the clinical privileges currently granted, such request for modification/enhancement of existing privileges must be made by submitting a formal amendment request describing the desired change(s). The amendment(s) or enhancement(s) must be requested through the appropriate Service Chief, the Chief of Staff, and granted by the Director. The amendment request will be accompanied by:

- 1) Full documentation to support the amendments/enhancements, such as documentation of training or practice which demonstrates competence in the privilege(s) requested; or
 - 2) Letter(s) of reference from peers who have trained, witnessed the training, or can otherwise attest to the requestor's proficiency in the area being amended.
- b. Such amendments will be added by the Medical Staff Office to the Service/Section-specific privilege document, which will be remanded to Medical Executive Council at its next scheduled meeting for ratification.

5.3-4 Telemedicine Privileges

- a. The initial appointment of practitioners to the Telemedicine Staff may be based upon:
- 1) The practitioner's full compliance with this hospital's credentialing and privileging standards, including submission of appointment application on Vetpro;
 - 2) Or, using this hospital's standards, reliance on information provided by the hospital(s) at which the practitioner routinely practices; or
 - 3) Or, if the hospital where the practitioner routinely practices is JCAHO-accredited and agrees to provide a comprehensive report of the practitioner's qualifications, reliance entirely on the credentialing and privileging of that other hospital.
- b. Reappointment of a Telemedicine Staff member's privileges may be based upon performance at this hospital, and, if insufficient information is available, upon information from the hospital(s) where the practitioner routinely practices.

5.4 Conditions for Privileges of Limited License Practitioners

5.4-1 Admissions

- a. Dentist, oral surgeon, clinical psychologist, optometrist, and podiatrist members may admit patients only if a physician member assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.
- b. When evidence of appropriate training and experience is documented, a limited license practitioner may perform the history or physical on his or her own patient. Otherwise, a physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, clinical psychology, optometry, or podiatry).

5.4-2 Surgery and High Risk Interventions by Limited License Practitioners

- a. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of Surgery or the Chief's designee.
- b. Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior

to major high-risk (as defined by the responsible Service) diagnostic or therapeutic interventions.

5.4-3 Medical Appraisal

All patients admitted for care in a hospital by a dentist, oral surgeon, clinical psychologist, optometrist, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Service(s).

5.5 Temporary Urgent Privileges

5.5-1 Circumstances

- a. Under the provisions of 38 USC 7405(a)(1) and appropriate VHA Directives, temporary (45-day) privileges may be granted after appropriate application when there is an urgent patient care need.
- b. Any physician granted temporary privileges is required to complete the full Credentialing and Privileging process.
- c. Termination of the temporary appointment will occur after 45 days unless converted to a standard appointment.

5.5-2 Application and Review

- a. Temporary privileges may be granted after the applicant completes the application procedure and the Medical Staff Office completes the application review process. The following conditions apply:
 - 1) There must first be verification of:
 - i) i) Current licensure;
 - ii) ii) Relevant training or experience;
 - iii) iii) Current competence;
 - iv) iv) Possession of current clinical privileges;
 - v) v) Ability to perform the privileges requested.
 - 2) The results of the National Practitioner Data Bank and state medical board queries have been obtained and evaluated.
 - 3) The applicant has:
 - vi) i) Filed a complete application with the Medical Staff Office;
 - vii) ii) No current or previously successful challenge to licensure or registration;
 - viii) iii) Not been subject to involuntary termination of medical staff

membership at another organization; and

- ix) iv) Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.
- b. There is no right to temporary privileges. Accordingly, temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's or AHP's qualifications, ability, and judgment to exercise the privileges requested.
- c. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.
- d. Temporary privileges may be granted by the Director (or his or her designee) on the recommendation of the Chief of Staff or the Service Chief where the privileges will be exercised, or either's designee.
- e. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

5.5-3 General Conditions and Termination

- a. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed as provided at Section 5.5-1(c), or earlier terminated as provided at Section 5.5-3(c), below.
- b. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, the responsible Service Chief, or the Director after conferring with the Chief of Staff and the responsible Service Chief. A person shall be entitled to the procedural rights afforded by Bylaws Article 13, Hearings and Appellate Reviews, only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.
- c. Whenever temporary privileges are terminated, the appropriate Service Chief or, in the Chief's absence, the Acting Service Chief shall assign a member to assume responsibility for the care of the affected practitioner's patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.
- d. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules.

5.6 Disaster and Emergency Privileges

- 5.6-1 Disaster Privileges may be granted when VASDHS's emergency management plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

- a. Disaster Privileges may be granted by the Director, based upon recommendation of the Chief of Staff, or in his or her absence, the recommendation of the responsible Service Chief, upon presentation of any of the following to the Emergency Privileging Coordinator:
 - 1) A current picture Hospital identification card;
 - 2) A current license to practice and a valid picture ID issued by a state, federal or regulatory agency;
 - 3) Local, state or federal identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT);
 - 4) Identification indicating that the practitioner has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;
 - 5) Presentation by current hospital or Medical Staff Member(s) with personal knowledge regarding the practitioner's identity;
 - 6) National Practitioner Databank inquiry, if communication is possible.
 - b. Disaster privileges will be granted for ten (10) days or for the duration of the disaster or emergency, whichever is shorter, or until communication is established and the provider can be converted to a Temporary Appointment for urgent patient care needs.
 - c. Persons granted Disaster Privileges shall wear identification badges denoting their status as a DMAT member.
 - d. The Medical Staff Office shall begin the process of verification of credentials and privileges as soon as the immediate situation is under control, using a process identical to that described as Section 5.5-2 (except that the individual is permitted to begin rendering services immediately, as needed).
 - e. The responsible Service Chief shall arrange for appropriate concurrent monitoring of the activities of practitioners granted Disaster Privileges.
 - f. Upon termination of the disaster, the provider will submit a complete application and full credentialing will be accomplished within 120 days in order to determine if any follow-up is required.
 - g. A physician, dentist, or other practitioner's privileges will be rescinded immediately by the Chief of Staff or his/her designee in the event any information or observation suggests the person is not capable of rendering necessary emergency services. There will be no rights to a hearing or review in the event emergency privileges are terminated, regardless of the reason for the termination.
- 5.6-2 In the event of an emergency, any member of the Medical Staff or credentialed AHP shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member or AHP shall promptly yield such care to a qualified member when one becomes available.

5.7 Transport and Organ Harvest Teams

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with VASDHS to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of their agreement with VASDHS.

References:

[VASDHS MCM 11-65, Setting Specific Privileges and Performance of Procedures](#)

ARTICLE 6

ALLIED HEALTH PROFESSIONALS

6.1 Qualifications of Allied Health Professionals

Allied health professionals (AHPs) are not eligible for Medical Staff membership. They are credentialed in a manner that is equivalent to and consistent with the process by which Medical Staff members are credentialed. These individuals function professionally under a Scope of Practice or Standardized Procedures, and provide patient care and treatment under the supervision of a duly appointed, credentialed, and privileged VASDHS physician, only if the AHPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. For the purposes of these Bylaws and Rules, use of the term "privileges" in relation to the practice of Nurse Practitioners, Clinical Nurse Specialists, Nurse Anesthetists, and Physician Assistants refers to patient care treatments, medications, and medical devices those AHPs are authorized to order, prescribe, or carry out under an approved scope of practice or standardized procedures, and with appropriate physician supervision.

6.2 Categories

The Director shall determine, based upon comments of the Medical Executive Council and such other information available, those categories of AHPs that shall be eligible to exercise privileges VASDHS. Such AHPs shall be subject to the supervision requirements developed in each service and approved by the appropriate Professional Standards Board, the Medical Executive Council, and the Director.

6.3 Privileges and Service Assignment

- 6.3-1 AHPs may exercise only those setting-specific privileges granted them under an appropriate Scope of Practice or Standardized Procedures by the Director. The range of privileges for which each AHP may apply and any special limitations or conditions to the exercise of such privileges shall be based on recommendations of the appropriate Professional Standards Board, subject to approval by the Medical Executive Council and the Director.
- 6.3-2 An AHP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for other practitioners, unless otherwise specified in the Rules.
- 6.3-3 Each AHP shall be assigned to the Service or Services appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws or the Rules, shall be subject to terms and conditions similar to those specified for practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP.

6.4 Prerogatives

The prerogatives which may be extended to an AHP shall be defined in the Rules and/or hospital policies. Such prerogatives may include:

- 6.4-1 Provision of specified patient care services under the supervision or direction of a Medical Staff member and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification.
- 6.4-2 Service on Medical Staff, Service, or hospital committees.
- 6.4-3 Attendance at the meetings of the Service to which the AHP is assigned, as permitted by the Service rules, and attendance at hospital education programs in the AHP's field of practice.

6.5 Responsibilities

Each AHP shall:

- 6.5-1 Meet those responsibilities required by the Rules and as specified for practitioners in [Section 2.6](#), Basic Responsibilities of Medical Staff Membership, as modified to reflect the more limited practice of the AHP.
- 6.5-2 Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient VASDHS for whom the AHP is providing services.
- 6.5-3 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

6.6 Procedural Rights of Allied Health Professionals

- 6.6-1 Fair Hearings and Appeal
AHPs shall be entitled to certain fair hearing and appeal rights, as described below:
 - a. AHP applicants shall have the right to challenge a recommendation of the appropriate Professional Standards Board and/or Medical Executive Council to deny or restrict requested privileges by filing a written grievance with the Medical Executive Council within 15 days of such action. Upon receipt of such a grievance, the Medical Executive Council or its designee shall conduct a review that shall afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a hearing as established by [Article 13, Hearings and Appellate Reviews](#), of the Bylaws and shall not be conducted according to the procedural rules applicable to such hearings. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Council or its designee shall make a decision based on the interview and all other information available to it.
 - b. An AHP holding clinical privileges who is subject to a recommendation of the appropriate Professional Standards Board and/or Service Chief to revoke,

restrict or not renew any or all of such AHP's privileges shall be entitled to the rights set forth below.

- 1) The affected AHP shall be given written notice of the recommended action.
- 2) The affected AHP shall have 10 days within which to request a Medical Executive Council review hearing of the action.
- 3) If review is requested, the affected AHP shall be given written notice of the general reasons for the action, and the date, time and place that the Medical Executive Council review hearing is scheduled. Such date shall afford the AHP at least 14 calendar days' notice.
- 4) The affected AHP and the Professional Standards Board, through its designated representative, shall each have 10 days to submit written information and argument in support of their positions.
- 5) The affected AHP shall have a right to appear at the Medical Executive Council hearing, to hear such evidence as the Professional Standards Board representative may present in support of the committee's recommended action, and to present evidence in support of the AHP's challenge to that recommendation. Neither party shall be represented by legal counsel in the hearing.
- 6) The Medical Executive Council may then, at a time convenient to itself, deliberate outside the presence of the parties.
- 7) The Medical Executive Council decision following such a hearing shall be effective immediately, but shall be subject to appeal to the Disciplinary Appeals Board.
- 8) The affected AHP shall be promptly informed, in writing, of the Medical Executive Council's decision, and of his or her right to appeal the decision.

6.6-2 Automatic Termination

Notwithstanding the provisions of [Section 6.6-1](#), above, an AHP's privileges shall automatically terminate, without review pursuant to Section 6.6-1 or any other section of the Medical Staff Bylaws, in the event the AHP's certification or license expires, is revoked, or is suspended.

6.6-3 Review of Category Decisions

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Director, who has the discretion to decline to review the request or to review it using any procedure the Director deems appropriate.

References:

[VADHS MCM 11-01, Professional Standards Board](#)
[VADHS MCM 11- 56 Credentialing and Privileging/Scope of Practice](#)

ARTICLE 7

ORGANIZATION OF THE MEDICAL STAFF

7.1 Medical Staff—General Provisions

7.1-1 Officers

There are no elected “officers” of the Medical Staff at the VASDHS.

7.1-2 Leadership

a. The Chief of Staff functions as the “President” of the Medical Staff. His or her duties shall include, but not be limited to:

- 1) Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;
- 2) Calling, presiding at, and being responsible for the agenda and minutes of all meetings of the Medical Staff;
- 3) Serving as chair of the Medical Executive Council;
- 4) Serving as an ex-officio member of all other Medical Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;
- 5) Appointing, in consultation with the Medical Executive Council, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the chairs of these committees;
- 6) Being a spokesperson for the Medical Staff in external professional and public relations;
- 7) Serving on liaison committees with the Director, Executive Leadership Team, and administration;
- 8) Regularly reporting to the Director on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the Director;
- 9) In the interim between Medical Executive Council meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;
- 10) Interacting with the Director and Executive Leadership Team in all matters of mutual concern within VASDHS;

- 11) Representing the views and policies of the Medical Staff to the Director and the Executive Leadership Team;
 - 12) Being accountable to the Director, in conjunction with the Medical Executive Council, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within VASDHS and for the effectiveness of the quality assurance, performance improvement, and utilization review programs; and
 - 13) Performing such other functions as may be assigned by these Bylaws, the Medical Staff, or the Medical Executive Council.
- b. Associate Chiefs of Staff
- 1) The Associate Chief of Staff for External Clinical Services (ACOS/ECS) has general responsibility and oversight of clinical quality assurance at Community Clinics, clinical contracting, and the Compensation and Pension examination program.
 - 2) The Associate Chief of Staff for Research (ACOS/R & D) has general responsibility for administration of the VASDHS research program, including clinical research, laboratory-based research, health systems research, and rehabilitation research.
 - 3) The Associate Chief of Staff for Nursing and Patient Care (ACOS/Nursing & PCS) Services has general responsibility for nursing and patient care administrative activities, with the exception of CRNAs who are organizationally aligned under Anesthesia Service.
 - 4) The Associate Chief of Staff for Education (ACOS/E) has general responsibility for patient and staff education, as well as management and oversight of all graduate medical and allied health education programs and initiatives.
 - 5) The Associate Chief of Staff for Health Care Analysis (ACOS/HCA) has general responsibility for performance improvement activities, data analysis, maintenance of medical records (paper and electronic), and for informatics planning, implementation, and security.
- c. Removal of the President
- 1) Although the Chief of Staff is not an elected officer, he or she may be removed through the processes described in VHA Directives and supplements thereto, consistent with these Bylaws. The Medical Staff participates in the decision to remove the President by recommending removal to the Director as a result of violation of these Bylaws or other action that results in the Chief of Staff's loss of privileges and/or membership in the Medical Staff. Questions or concerns about removal procedures should be directed to the Veterans Integrated Service Network Director (VISN), and/or the Chief Network Officer, Headquarters, Washington, DC, and/or the Office of the Regional Counsel.

7.1-3 Function

- a. The Medical Staff, through its committees, Services, and Service Chiefs, provides counsel and assistance to the Chief of Staff, Director, Executive Leadership Team, Strategic Planning Council, and Performance Improvement

Council, regarding all facets of the patient care programs and services, including performance improvement, clinical care, education, research, staffing, informatics, etc.

- b. All Medical Staff members are eligible for membership on the Medical Executive Council and any member of the Medical Staff may place an issue or concern on the agenda with two (2) weeks notice and may represent it before Medical Executive Council. Medical Executive Council meetings are open, except when Medical Executive Council votes to go into Executive Session, which will occur when issues related to a specific practitioner are discussed. At such times, only members of the Medical Staff will remain to take part in deliberations and recommendations.
- c. All members understand the purposes and functions of the Medical Staff and demonstrate willingness to ensure that patient welfare always takes precedence over other concerns.

7.1-4 Self-Governance

- a. The Director will be responsible for the proper and efficient management of the facility. The Chief of Staff is delegated responsibility for the efficient management of the Medical Staff. Each clinical service is a component of the Medical Staff as a whole and will have a Service Chief, appointed under current VA Regulations, responsible to the Chief of Staff for the functioning of the service and vested with responsibility for general supervision of the clinical, educational, and research activities of the service. This includes, but is not limited to, accountability for all professional, administrative, and organizational activities and obligations of the service and quality and appropriateness of patient care provided by the service, which is assessed and improved on a continuous basis.
- b. Programmatic, multidisciplinary performance improvement processes will be reported to the involved services and to the appropriate oversight group, such as the Performance Improvement Council, which shares its reviews and recommendations with Medical Executive Council. All members of the Medical Staff are encouraged to participate in performance improvement opportunities through Service, council/committee efforts, or VASDHS sponsored performance improvement programs.

ARTICLE 8

COMMITTEES

8.1 General

8.1-1 Designation

The Medical Executive Council and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Council or a Service to perform specified tasks. Any committee—whether Medical Staff-wide, Service, program, or other clinical unit, standing or ad hoc—that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

8.1-2 Appointment of Members

- a. Unless otherwise specified, the chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the Service Chief, Medical Executive Council, and the Director. Medical Staff committees shall be responsible to the Medical Executive Council.
- b. The Director, or his or her designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.
- c. Each committee chair may appoint a co-chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

8.1-3 Representation on Hospital Committees and Participation in Hospital Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on hospital committees established to perform such functions.

8.1-4 Ex Officio Members

The Chief of Staff and the Director, or their respective designees are ex officio members of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.

8.1-5 Action Through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Council shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff members, and the Director regarding hospital staff.

8.1-6 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Council. Any committee member who is appointed by the Service Chief may be removed by a majority vote of his or her Service committee or the Medical Executive Council.

8.1-7 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 10, Meetings.

8.1-8 Attendance of Nonmembers

Any Medical Staff member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Bylaws and Rules applicable to that committee.

8.1-9 Accountability

All committees organized under the Medical Executive Council shall be accountable to the Medical Executive Council.

8.2 Medical Executive Council

8.2-1 Composition

The Medical Executive Council shall be composed of the Chief of Staff, Associate Chiefs of Staff, all Service Chiefs who have Medical Staff members assigned to their Services, as well as the Chiefs of Pharmacy and Social Work, and members of the Medical Staff who the chair, with endorsement of the Medical Executive Council, may appoint from time to time. The Director, Associate Director, Executive Director of Firm Clinics, and Chief of Performance Improvement Management Service are ex-officio members, and are without voting rights. The Chief of Staff shall chair the Medical Executive Council. A majority of the committee shall be physicians.

8.2-2 Duties

With the assistance of the Chief of Staff, the Medical Executive Council shall perform the duties listed below.

- a. Supervise the performance of all Medical Staff functions, which shall include:
 - 1) Requiring regular reports and recommendations from the Services, and committees concerning discharge of assigned functions;
 - 2) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

- 3) Following up to assure implementation of all directives.
- b. Coordinate the activities of the committees and clinical services.
- c. Assure that the Medical Staff adopts bylaws and rules establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual privileges, the organization of the quality assessment and improvement activities of the Medical Staff, as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures.
- d. Based on input and reports from the Services and the Professional Standards Board, assure that the Medical Staff adopts Bylaws, Rules or regulations establishing criteria and standards for medical staff membership and privileges that are consistent with federal law, JCAHO standards, and VA, VHA, and VASDHS regulations and directives and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, professional competence, and character of applicants and Staff members.
- e. Assure that the Medical Staff adopt Bylaws, Rules, or regulations establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and Services, and review and analysis of patient medical records.
- f. Evaluate the performance of practitioners exercising clinical privileges whenever there is doubt about an applicant's, member's, or AHP's ability to perform requested privileges.
- g. Based upon input from the Services and the Professional Standards Board, make recommendations regarding all applications for Medical Staff appointment, reappointment, and privileges.
- h. When indicated, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff members.
- i. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:
 - 1) Ethical standards;
 - 2) The Medical Staff Bylaws, Rules, and policies;
 - 3) VA, VHA, and VASDHS rules, regulations, initiatives, and policies;
 - 4) Federal laws and regulations; and
 - 5) JCAHO accreditation requirements.
- j. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.
- k. Implement, as it relates to the Medical Staff, the approved policies of VASDHS.
- l. With the Service Chiefs, set Service objectives for establishing, maintaining and enforcing professional standards within VASDHS and for the continuing improvement of the quality of care rendered VASDHS; assist in developing programs to achieve these objectives.

- m. Regularly report to the Director through the Chief of Staff on at least the following:
 - 1) Outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Director that quality of care is consistent with professional standards; and
 - 2) General status of any Medical Staff disciplinary or corrective actions in progress.
- n. Review and make recommendations to the Director regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Council shall assist VASDHS in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements or other agreements, in evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements, and in providing relevant input to mechanisms that may be implemented by hospital administration in making exclusive contracting decisions.
- o. Assure that educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.
- p. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Council.
- q. Establish the date, place, time and program of the regular meetings of the Medical Staff.
- r. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.

8.2-3 Meetings

The Medical Executive Council should be scheduled to meet on a monthly basis and shall meet at least 10 times during the calendar year. A permanent record of its proceedings and actions shall be maintained.

8.2-4 Quorum

A quorum for the purpose of the Medical Executive Council is defined as 50% of the voting members.

8.2-5 Closed Session

When necessary to consider issues of credentialing and privileging, or actions against privileges, of members of the Medical Staff, the Medical Executive Council shall sit in closed session and only members of the Medical Staff may attend. All other participants of the regular Council meeting will be excused.

8.3 Professional Standards Board

8.3-1 Composition

The Professional Standards Board is the designated hospital credentialing committee for physicians, dentists, podiatrists, optometrists, clinical psychologists, certified

nurse anesthetists, and physician assistants, and shall be composed of the Chief of Staff, a representative from Human Resources Management Service, and the Service or Section Chief representing the specialty of the individual whose credentials are under review.

8.3-2 Duties

The Professional Standards Board is constituted to examine all documents and pertinent information concerning the appointment, advancement, and probationary review of clinical staff, as noted in 8.3-1, in order to ensure that the VHA recruits and retains the best-qualified professional personnel. Its functions include, but are not limited to:

- a. Review and recommend action to the Director, through the Medical Executive Council, the acceptance or rejection of each application for appointment and action on each request for initial privileges.
- b. Review and recommendation on proposals for special advancement for performance and/or achievement for members of the Medical Staff.
- c. Review and recommend to the Director, in accordance with [MCM 11-1 “Professional Standards Board”](#) and appropriate VHA Directives and supplements thereto, action on all policies and procedures for appointment, promotion, and advancement of Title 38 allied health professionals.

8.4 Standing Councils and Committees

A Medical Staff Committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; allied health professionals; representatives from VASDHS administrative services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with vote unless the statement of committee composition designates the position as nonvoting. Medical Staff committees and councils shall submit their minutes to the Chief of Staff who will bring the pertinent information from those minutes to the attention of the Medical Executive Council. The Chief of Staff may, from time to time, ask other committees or councils to present to Medical Executive Council as part of the strategic planning and performance improvement process.

8.4-1 Council/Committee Records

- a. Councils/Committees prepare minutes that report data, conclusions, recommendations, actions taken, and outcomes of actions taken. Minutes will be forwarded in a timely manner to the Chief of Staff who will provide them to the Medical Executive Council.
- b. Councils/Committees provide appropriate and timely communication to individual Services regarding any concerns or specific action taken that pertains to the Service and its providers.
- c. Provider-specific information reviewed by any committee will be forwarded to the Performance Improvement Management Service for inclusion in each provider’s peer information file.

8.4-2 Council/Committee Attendance

Assigned Medical Staff members, or their designated alternates, will regularly attend meetings of councils/committees of which they are members, unless specifically excused by the chair for appropriate reasons that shall include, but not be limited to, illness, leave, and clinical obligations. Minutes will specify members present, absent, alternates, as well as resource staff and guests of the committee. Failure of any Medical Staff member to take his/her council/committee assignment seriously, attend meetings regularly, and engage in deliberations of the council/committee, will be brought to the attention of the Chief of Staff by the chair. The Chief of Staff will discuss the staff member's lack of involvement in the council/committee with his/her Service Chief, who will be responsible for ensuring participation in, or providing a replacement on, the council/committee. Notification of membership on a council/committee reporting to the Medical Executive Council will occur by letter from the office of the Chief of Staff to the individual after approval of his/her supervisor. A copy will be sent to the chair of the committee/council. A chair may ask to have a member replaced for failure to attend or make meaningful contributions to the council's/committee's deliberations. A member may ask to be relieved at any time unless they serve by virtue of the position they hold in the VASDHS. Chairs will be appointed after MEC endorsement. Council/committee membership will not be time limited.

ARTICLE 9

SERVICES AND SECTIONS

9.1 Organization of Clinical Services

Each Service shall be organized as an integral unit of the Medical Staff and shall have a Chief who is selected and appointed under current VA/VHA regulations, who is accountable to the Director, through the Chief of Staff, for the functioning of the Service. The Service Chief shall have the authority, duties, and responsibilities specified in the Rules.

Additionally, each Service may appoint a Service committee and such other standing or ad hoc committees, as it deems appropriate to perform its required functions. The composition and responsibilities of each standing Service committee shall be specified in the Rules. Services may also form Sections as described in Section 9.6, Sections.

9.2 Designation

9.2-1 Current Designation

The current Clinical Services are:

- a. Anesthesia
- b. Audiology and Speech Pathology
- c. Dental
- d. Education
- e. External Clinical Services
- f. Healthcare Analysis
- g. Medicine
- h. Neurology
- i. Nuclear Medicine
- j. Nursing and Patient Care Services
- k. Pathology and Laboratory
- l. Pharmacy
- m. Physical Medicine and Rehabilitation
- n. Psychiatry
- o. Psychology
- p. Radiology
- q. Social Work
- r. Spinal Cord Injury
- s. Surgery

9.2-2 Future Services

The Medical Executive Council will periodically restudy the designation of the Services and recommend to the Director what action is desirable in creating,

eliminating, or combining Services for better organizational efficiency and improved patient care. Action shall be effective upon approval by the Medical Executive Council and the Director.

9.3 Assignment to Services

Each member shall be assigned membership in at least one Service, but may also be granted membership and/or clinical privileges in other Services consistent with the practice privileges granted.

9.4 Functions of Services

The Services shall fulfill the clinical, administrative, quality improvement, risk management, utilization management, and collegial and education functions described in the Rules. When the Service or any of its committees meets to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committees. Each Service or its committees, if any, must meet regularly to carry out its duties.

Each Service will meet monthly (no less than ten times a calendar year) and will maintain a file of minutes of such meetings, documenting discussion of appropriate service business. Such business includes, but is not limited to, review of clinical activities, identification of opportunities to improve, review of Service-related performance outcomes, timely responses to facility, network, and organizational initiatives, directives, policies, and mandates, and recommendations for action. Minutes of meetings will be kept and a copy forwarded to the Chief of Staff as Chair of the Medical Executive Council. The Chief of Staff or the Service Chief will bring Service-specific information, recommendations, and/or concerns to the Medical Executive Council or other appropriate councils. All clinical services are integrated into the overall functioning of the VASDHS and participate in planning and executing its strategic initiatives, ensuring that Service activities are congruent with organizational strategic goals and objectives.

9.5 Service Chief

9.5-1 Qualifications

- a. Service Chiefs of physician services shall be active Medical Staff members, shall have demonstrated ability in at least one of the clinical areas covered by the Service, shall be board certified, and shall be willing and able to faithfully discharge the functions of his or her office. Specific qualifications shall be set forth in the Rules.
- b. Service Chief of non-physician clinical services (e.g., Pharmacy, Social Work, Psychology) shall have demonstrated similar ability in their respective files and will be appointed to membership on the Medical Executive Council.

9.5-2 Selection

Clinical Service Chiefs are appointed by the Director based upon the recommendation of a search committee chaired by the Chief of Staff, the Medical Executive Council, the Affiliation Partnership Council, the appropriate Professional Standards Board, as well as the VISN 22 Director, and Headquarters Program Official, as may be required by VHA Regulations.

9.5-3 Roles and Responsibilities of Clinical Service Chiefs

Specific roles and responsibilities of Service officers shall be as set forth in the Rules.

9.6 Sections

Within each Service, the practitioners of the various specialty groups may organize themselves as a clinical Section. While Sections may assist Services in performance of Service functions, responsibility and accountability for performance of Service functions shall remain at the Service level.

ARTICLE 10

MEETINGS

10.1 Medical Staff Meetings

10.1-1 Medical Staff Meetings

There shall be at least one meeting of the Medical Staff during each calendar year. The Chief of Staff shall determine the date, place, and time of the meeting. The Chief of Staff shall present a report on significant actions taken by the Medical Executive Council during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. No business shall be transacted at any Medical Staff meeting except that stated in the notice calling the meeting.

10.1-2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Council, or Director, or upon the written request of ten percent of the voting members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.2 Service and Committee Meetings

10.2-1 Regular Meetings

Services and committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. Each Service shall meet regularly, at least 10 times per calendar year, to review and discuss patient care activities and to fulfill other Service responsibilities.

10.2-2 Special Meetings

A special meeting of any Service or committee may be called by, or at the request of, the chair thereof, the Medical Executive Council, Chief of Staff, or by 33-1/3 percent of the group's current members, but not fewer than three members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.3 Quorum

10.3-1 Medical Staff Meetings

The presence of 25 percent of the voting Medical Staff members at any regular or special meeting shall constitute a quorum.

10.3-2 Committee Meetings

The presence of 50 percent of the voting members shall be required for Medical Executive Council meetings. For other committees, a quorum shall consist of 50

percent of the voting members of a committee but in no event less than three voting committee members.

10.3-3 Service Meetings

The presence of 15 percent of the voting Medical Staff members at any regular or special Service meeting shall constitute a quorum.

10.4 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Committee action may be conducted by teleconference, which shall be deemed to constitute a meeting for the matters discussed in that teleconference. Valid action may be taken without a meeting if at least 10 days' notice of the proposed action has been given to all members entitled to vote, and it is subsequently approved by electronic or written vote setting forth the action so taken, which is signed by at least two-thirds of the members entitled to vote. The meeting chair shall refrain from voting except when necessary to break a tie.

10.5 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer or his or her designee and forwarded through the Chief of Staff to the Medical Executive Council or other designated committee and the Director. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by federal law.

10.6 Attendance Requirements

10.6-1 Regular Attendance Requirements

Each member of a Medical Staff category required to attend meetings under [Rule 1.3, Prerogatives and Responsibilities](#), shall be required to attend general staff meetings Service or Section meetings during the two-year reappointment period. Failure to attend such meetings may be considered grounds for termination of clinical privileges.

10.6-2 Special Appearance

A committee, at its discretion, may require the appearance of a practitioner during a review of the clinical course of treatment regarding a patient. If possible, the chair of the meeting should give the practitioner at least ten days' advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given special notice shall (unless excused by the Medical Executive Council upon a showing of good cause) result in an automatic suspension of the practitioner's privileges for at least two weeks, or such longer period as the Medical Executive Council deems appropriate. The practitioner shall be entitled to the procedural rights described at [Article 13, Hearings and Appellate Reviews](#).

10.7 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order, however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

ARTICLE 11

CONFIDENTIALITY, IMMUNITY, RELEASES, AND INDEMNIFICATION

11.1 General

Medical Staff, Service, Section or committee minutes, files and records—including information regarding any member or applicant to this Medical Staff—shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff Committee files and shall not become part of any particular patient’s file or of the general hospital records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.

11.2 Breach of Confidentiality

Inasmuch as effective credentialing, quality improvement, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of Medical Staff Services, Sections, or committees, except in conjunction with another health facility, professional society or licensing authority peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of VASDHS. If it is determined that such a breach has occurred, the Medical Executive Council may undertake such corrective action as it deems appropriate.

11.3 Access to and Release of Confidential Information

11.3-1 Access for Official Purposes

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

- a. Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.
- b. Medical Staff and Service managers, and their authorized representatives, for the purpose of fulfilling any authorized function of such manager.
- c. The Director and his or her authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.

11.3-2 Member’s Access

- a. A Medical Staff member shall be granted access to his or her own credentials file, subject to the following provisions:

- 1) Notice of a request to review the file shall be given by the member to the Chief of Staff (or his or her designee) at least three days before the requested date for review.
 - 2) The member may review the file in its entirety, but may not copy or remove the file or any contents within the file.
 - 3) The review by the member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Chief of Staff present.
- b. A member may be permitted to request correction of information as follows:
- 1) After review of his or her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.
 - 2) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Council in closed session whether to make the correction as requested. The Medical Executive Council shall make the final determination.
 - 3) The member shall be notified promptly, in writing, of the decision of the Medical Executive Council.
 - 4) In any case, a member shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the Medical Executive Council, and shall be placed in the credentials file immediately following review by the Medical Executive Council.

11.4 Immunity and Releases

11.4-1 Immunity from Liability for Providing Information or Taking Action

Each representative of the Medical Staff and hospital and all third parties shall be exempt from liability to an applicant, member, or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, hospital or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at this hospital or by reason of otherwise participating in a Medical Staff or hospital credentialing, quality improvement, or peer review activities.

11.4-2 Activities and Information Covered

a. **Activities**

The immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

- 1) Applications for appointment, privileges, or specified services;
- 2) Periodic reappraisals for reappointment, privileges, or specified services;
- 3) Corrective action;

- 4) Hearings and appellate reviews;
- 5) Quality improvement review, including patient care audits;
- 6) Peer review;
- 7) Utilization reviews;
- 8) Morbidity and mortality conferences; and
- 9) Other hospital, Service, Section, or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

b. **Information**

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

11.5 Releases

Each practitioner shall, upon request of VASDHS, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

11.6 Cumulative Effect

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

11.7 Indemnification

VASDHS shall indemnify, defend, and hold harmless the medical staff and its individual members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

11.7-1 As a member of or witness for a medical staff department, service, committee, or hearing panel;

11.7-2 As a member of or witness for the Director or any hospital task force, group or committee; and

11.7-3 As a person providing information to any Medical Staff or hospital group, officer, member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant.

VASDHS shall retain responsibility for the sole management and defense of any such claims, suits, investigations, or other disputes against Indemnitees, including but not limited

to selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws. In no event will VASDHS indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitee's private economic interests.

ARTICLE 12

PERFORMANCE IMPROVEMENT AND CORRECTIVE ACTION

12.1 Peer Review Philosophy

12.1-1 Role of Medical Staff in Organization-wide Quality Improvement Activities

The Medical Staff is responsible to oversee the quality of medical care, treatment, and services delivered at VASDHS. An important component of that responsibility is the oversight of care rendered by members and AHPs practicing at VASDHS. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal corrective measures and/or corrective action as necessary to achieve and assure quality of care, treatment, and services. It is the policy of VASDHS to maintain a constructive, efficient work environment in which both management and employees recognize and carry out their responsibilities. Necessary disciplinary or adverse action is taken without regard to marital status, political affiliation, race, color, religion, sex, national origin, or age. Adverse action based on an employee's medical condition is not taken when the employee can perform assigned duties. Disciplinary or adverse action is taken only when necessary and then promptly and equitably. The purpose of discipline is to correct an employee's conduct and behavior. Penalties must not be disproportionate to offenses and are applied as consistently as possible, considering the particular circumstances surrounding the cause for disciplinary action. Disciplinary and performance based privilege changes are undertaken after due process procedures are exhausted, consistent with guidance outlined in [VHA Handbook 1100.19](#), and supplements thereto, and regulations regarding the Healthcare Integrity and Protection Data Bank (HIPDB) relevant to credentialing and privileging of physicians, dentists, podiatrists, optometrists, and psychologists. Toward these ends:

- a. Members of the Medical Staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess, and improve performance of their peers at VASDHS.
- b. The goals of the peer review processes are to prevent, detect, and resolve problems and potential problems through routine collegial monitoring, education and counseling. However, when necessary, corrective measures, including formal investigation and discipline, will be implemented and monitored for effectiveness.
- c. Peers in the Services and committees are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful, and ongoing. The term "peers" generally requires that a majority of the peer reviewers be members holding the same license as the practitioner being reviewed, including, where possible, at least one member practicing the same specialty as the member being reviewed. Notwithstanding the foregoing, D.O.s and M.D.s shall be deemed to hold the "same licensure" for purposes of participating in peer review activities.

12.1-2 Peer Review of Patient Events, Complaints, and Corrective Actions

- a. The Peer Review Committee (PRC) shall function as the coordinating body for the confidential evaluation of practitioner professional performance (see MCM 11-55). Where needed, the Peer Review Committee shall determine the need for and assign responsibilities for additional evaluations utilizing chart review, monitoring of clinical practice patterns, simulation, proctoring, external review or other monitoring processes.
- b. Any member of the Medical Staff or other professional or administrative staff may bring a concern regarding the performance or conduct of a member of the Medical Staff to the attention of the Chief of Staff and the Peer Review Committee either directly or may enter a Patient Event Report. The Service Chief and Chief of Staff shall evaluate the grounds for an expressed concern or complaint and, if appropriate, arrange an informal conference with the affected Physician and document the proceeding as an initial Peer Review or initiate an initial Peer Review. In no event shall the person initiating the complaint participate in the initial Peer Review.
- c. The initial Peer Review shall include a review of the issue(s), determination of adherence to standards of care, and recommendation for resolution of the problem. The PRC, on receipt of any event determined to deviate from standards of practice shall provide an opportunity for the practitioner to respond in writing or in person. Any informal actions, monitoring, or counseling should be documented. If the problem is resolved, a written report outlining the substance of the complaint and the resolution shall be prepared and placed in the Physician's Peer Review file.
- d. When other Committees of the Medical Staff identify concerns or issues that may suggest deviation from the provision of safe, high quality patient care, these concerns will similarly be presented to the PRC and addressed as described above and in MCM 11-55. Triggers for additional evaluation may include but are not limited to:
 - 1) Individual or repeating patient events determined by the PRC to be significant deviations from the standard of care without adequate explanation.
 - 2) Failure to adhere to National Patient Safety Goal standards at the 90% or greater level.
 - 3) Significant or repeated failure to comply with standards for timely medical record documentation.
- e. The PRC, through the appropriate Service Chief, may counsel, educate, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and counseling may be issued orally or in writing. The decision to assign a period of performance monitoring to further assess current competence will be based on the evaluation of the practitioners current clinical competence, practice behavior, and ability to perform the indicated or requested privileges.
- f. Medical Executive Council approval is not required for such actions, although the actions shall be reported to the Chief of Staff and Professional Standards Board. The actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article 13, Hearings and Appellate Reviews. If the problem is not resolved, the Chief of Staff will refer the matter for Formal Corrective Action pursuant to Article 12.1-3, below.

- g. The informal problem resolution process is a privileged and confidential peer review process and considered confidential and protected under 38 U.S.C. § 5705. All proceedings, findings, conclusions, and recommendations in connection with this process are privileged, confidential, are not public records, and are not available for court subpoena or discovery proceedings.
- h. When problem resolution through the Peer Review Process has been ineffective or when the findings of the PRC suggest a formal practice evaluation is needed, then the PRC may request a formal administrative review. Any information gathered or utilized as part of the confidential peer review shall not be made available to the administrative review process.

12.1-3 Criteria for Initiation of Formal Corrective Action

A formal corrective action investigation may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor, or conduct, either within or outside of VASDHS, which is reasonably likely to be:

- a. Detrimental to patient safety or to the delivery of quality patient care within VASDHS;
- b. Unethical;
- c. Contrary to the Medical Staff Bylaws or Rules;
- d. Below applicable professional standards;
- e. Disruptive of Medical Staff or hospital operations; or
- f. An improper use of hospital resources.

Generally, formal corrective action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action. Any recommendation of formal corrective action must be based on evaluation of applicant-specific information. All formal disciplinary and adverse action(s) undertaken in regard to a member of the Medical Staff will be governed by VHA regulations.

12.1-4 Initiation

- a. Any person who believes that formal corrective action may be warranted may provide information to the Peer Review Committee, Chief of Staff, Service Chief, the Executive Leadership Team, or the Director.
- b. If the Peer Review Committee, Chief of Staff, the Executive Leadership Team, or the Director determines that corrective action may be warranted under Section 12.1-3, that person, or entity may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed orally or in writing.
- c. The Chief of Staff shall notify the Director or his or her designee in his or her absence, and the Medical Executive Council, in a closed executive session, and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any investigation, provided, however, that the Chief of Staff or the Medical Executive Council may dispense with further investigation of matters

deemed to have been adequately investigated by a committee pursuant to [Section 12.1-6](#) or otherwise.

12.1-5 Expedited Initial Review

- a. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee may, on behalf of the Medical Executive Council, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Council in a closed executive session, which shall decide whether to initiate a formal corrective action investigation.

12.1-6 Formal Investigation

- a. If the Medical Executive Council concludes action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation.
 - 1) If the Medical Executive Council or the Director conclude a formal investigation is warranted, it shall direct an investigation to be undertaken. The Chief of Staff will initiate a timely investigation. An Administrative Board of Investigation, a Summary Review Board (conducted by the Professional Standards Board), or a Physical Standards Board may conduct the investigation, depending upon the reported concerns. If the findings of the investigation support the charges, appropriate disciplinary action will be taken. If findings of the investigation do not support the charges, the practitioner will be returned to full privileges.
- b. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to firm up an uncertain or controversial review or to engage specialized expertise). If the investigation is delegated to a Medical Staff member or committee other than the Medical Executive Council, such member or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Council through the Chief of Staff as soon as practicable. The report may include recommendations for appropriate corrective action.
- c. Prior to any adverse action being approved, the Medical Executive Council shall assure that the member was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Council, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in [Article 13, Hearings and Appellate Reviews](#), nor shall the hearings or appeals rules apply.
- d. Despite the status of any investigation, at all times the Medical Executive Council shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action, consistent with VA, VHA, and VASDHS rules, regulations, and directives.

12.1-7 Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Council shall take action including, without limitation:

- a. Determining no corrective action should be taken and, if the Medical Executive Council determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member's file;
- b. Deferring action for a reasonable time;
- c. Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude Service Chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
- d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation, monitoring, proctoring, continuing medical education;
- e. Recommending reduction, modification, suspension, or revocation of privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated, consistent with VHA rules, regulations, and directives;
- f. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- g. Recommending suspension, revocation, or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated; and
- h. Taking other actions deemed appropriate under the circumstances, including detail or reassignment to non-patient care activities.
- i. Completion of any of the above processes or activities without additional evidence of improvement in performance as measured by peer review will not automatically result in restoration of privileges.
- j. Separation of a member from the Medical Staff, denial of staff appointments, appeals, and grievances will be governed by applicable VA and VHA rules, regulations, and directives.

12.1-8 Time Frames

Insofar as feasible under the circumstances, formal and informal investigations should be conducted expeditiously, as follows:

- a. Initial Peer Review (e.g. informal investigation) shall be completed and the results should be reported to the Peer Review Committee within 45 days.
- b. The Peer Review Committee will complete their additional review within 120 days of the event report.
- c. Other formal investigations should be completed and the results should be reported within 90 days.

12.1-9 Procedural Rights

- a. If the Medical Executive Council determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Director. The Director may affirm, reject, or modify the action. The Director shall give great weight to the Medical Executive Council's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Council and the Medical Executive Council still has not acted. The decision shall become final if the Director affirms it or takes no action on it within 70 days after receiving the notice of decision.
- b. If the Medical Executive Council recommends an action that is a ground for a hearing under Section 13.2, the Chief of Staff shall give the practitioner special notice of the adverse recommendation and of the right to request a hearing. The Director may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

12.1-10 Initiation by Director

- a. The Medical Staff acknowledges that the Director must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of VASDHS in the event that the Medical Staff fails in any of its substantive duties or responsibilities.
- b. Accordingly, if the Medical Executive Council fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Director may direct the Medical Executive Council to initiate an investigation or disciplinary action, but only after consulting with the Medical Executive Council. If the Medical Executive Council fails to act in response to that direction, the Director may, in furtherance of the Director's ultimate responsibilities and fiduciary duties, initiate corrective action, but must comply with applicable provisions of Article 12, Performance Improvement and Corrective Action, and Article 13, Hearings and Appellate Reviews, of these Bylaws. The Director shall inform the Medical Executive Council in writing of what it has done.

12.2 Summary Restriction or Suspension

12.2-1 Criteria for Initiation

- a. Whenever a practitioner's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, summary suspension of privileges on a temporary basis may be made by the Director, on the recommendation of the Chief of Staff, pending the outcome of a formal action or investigation, consistent with the requirements in VHA regulations on Credentialing and Privileging. The summary suspension pending investigation is not reported to the National Practitioner Databank (NPDB). Final action arising from the investigation following summary suspension that adversely affects privileges for a period longer than 30 days is reportable to the NPDB and the appropriate State Licensing Board(s). Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition. The involved practitioner will receive notice from the Director and the Chief of Staff that privileges are summarily suspended. The notice shall generally describe the reasons for the action. The practitioner will be temporarily reassigned to an administrative position or placed on administrative leave. Indications

for summary suspension of clinical privileges include, but are not limited to, the following:

- 1) Significant deficiencies in clinical practice such as lack of diagnostic or treatment capability; multiple errors in transcribing, administering or documenting medications; inability to perform clinical procedures considered basic to the performance of one's occupation, or performing procedures not included in one's clinical privileges in other than emergency situations;
 - 2) Patient neglect or abandonment;
 - 3) Mental health impairment sufficient to cause the individual to make judgment errors affecting patient safety, to behave inappropriately in the patient care environment, or to provide unsafe patient care;
 - 4) Physical health impairment sufficient to cause the individual to provide unsafe patient care;
 - 5) Substance abuse when it affects the individual's ability to perform appropriately as a health care provider or in the patient care environment;
 - 6) Falsification of credentials;
 - 7) Falsification of medical records or prescriptions;
 - 8) Theft of drugs;
 - 9) Inappropriate dispensing of drugs;
 - 10) Unethical behavior or moral turpitude (such as sexual misconduct toward any patient involved in VA health care);
 - 11) Patient abuse, including mental, physical, sexual, and verbal abuse, and including any action or behavior that conflicts with a patient's rights identified in Title 38, Code of Federal Regulations (CFR); intentional omission of care; willful violations of a patient's privacy; willful physical injury, or intimidation, harassment or ridicule of a patient.
 - 12) Falsification of research findings, regardless of where the research was carried out or the funding source;
 - 13) Major or intractable delinquencies of medical records;
 - 14) Failure to meet other professional or organizational obligations, including mandatory education, training, or certification.
- b. The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, the member's patients shall be promptly assigned to another individual with appropriate clinical privileges by the Service Chief or designee considering, where feasible, the wishes of the patient and the affected practitioner in the choice of a substitute member.
- c. When suspension as a disciplinary action is being considered, legal counsel will be consulted. Legal counsel should be sought early when the performance of a member of the Medical Staff is such that, in the opinion of the Chief of Staff or the member's supervisor(s), the Staff member's continued exercise of clinical privileges would likely lead to serious harm to the patients under his or her care.

12.2-2 Procedural Rights

Unless the Medical Executive Council terminates the summary action, it shall remain in effect until completion of the corrective action process and of the hearing and appellate review process. When a summary action is continued, the affected practitioner shall be entitled to the procedural rights afforded by Article 13, Hearings and Appellate Reviews.

12.2-3 Initiation by Director

- a. If the Chief of Staff is not available to recommend a summary action to summarily restrict or suspend a member's membership or privileges, the Director (or designee) may immediately suspend or restrict a member's privileges if a failure to act immediately may result in imminent danger to the health of any individual, provided that the Director (or designee) made reasonable attempts to contact the Chief of Staff and the Chief of the Service to which the member is assigned before acting.
- b. Such summary action is subject to ratification by the Medical Executive Council. If the Medical Executive Council does not ratify such summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

12.3 Automatic Suspension

In the following instances, the member's privileges or membership may be suspended or limited as described:

12.3-1 Licensure

- a. Revocation, Suspension or Expiration: Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended, or expired without an application pending for renewal or the member fails to submit documents (such as cases performed at other institutions, if requested), Medical Staff membership and privileges shall be automatically revoked as of the effective date of such revocation, suspension, or expiration.
- b. The automatic suspension shall be for the same period that such license (or equivalent legal credential) is suspended, or other appropriate action is concluded, as required. After 29 days, the individual may request termination of his or her appointment. If no such request is received, the practitioner will be suspended and, after 30 more days, reported to the appropriate State Licensing Board(s), as required. During such a suspension, the practitioner, if paid by VASDHS, will be placed on leave without pay. No right to a hearing or appellate review exists under these conditions.

12.3-2 Involuntary Separations

- a. In effecting involuntary separations of employees serving under 38 U.S.C., 7405, the procedural requirements prescribed for separations, such as reviews by the Professional Standards Board or Disciplinary Board, do not apply.
- b. Although not required, employees should, where feasible, be given such advance notice of separation as determined appropriate by the approving official.
- c. The employee will not be entitled to a review of the involuntary separation.
- d. The provisions of [VHA Handbook 1100.18 – Reporting and Responding to State Licensing Boards](#), will govern VASDHS' actions related to reporting such occurrence.

- 12.3-3 **Failure to Satisfy Special Appearance Requirement**
A member who fails without good cause to appear and satisfy the requirements of Section 10.6-2 shall automatically be suspended from exercising all or such portion of privileges as the Medical Executive Council specifies.
- 12.3-4 **Medical Records**
Medical Staff members are required to complete medical records within the time prescribed by the Medical Executive Council. Failure to timely complete medical records shall result in an automatic suspension after notice is given as provided in the Rules. Such suspension shall apply to the Medical Staff member's right to admit, treat or provide services to new patients at VASDHS, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating. The suspension shall continue until the medical records are completed. If after 30 consecutive days of suspension the member remains suspended, the member shall be considered to have voluntarily resigned from the Medical Staff.
- 12.3-5 **Failure to Comply with Government and Other Third Party Payor Requirements**
The Medical Executive Council shall be empowered to determine that compliance with certain specific third party payor, government agency, and professional review organization rules or policies is essential to hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The Rules may authorize the automatic suspension of a practitioner who fails to comply with such requirements. The suspension shall be effective until the practitioner complies with such requirements.
- 12.3-6 **Termination of Appointment**
- a. Termination of Medical Staff appointments will be accomplished by following procedures set forth in appropriate VHA Directives, and for contract employees in federal and VA acquisition regulations, and/or where appropriate, in relevant VHA Directives.
 - b. Termination of appointments of paid consultants, contract attendings, without compensation, and fee basis staff, in accordance with VA Handbook 5005, shall occur on the date specified in any time-limited appointment or at the discretion of the Director when the services of such personnel are no longer needed. Whenever possible, advance notice of termination will be given.
 - c. If a practitioner is suspended for more than six months, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.
- 12.3-7 **Medical Executive Council Deliberation and Procedural Rights**
- a. As soon as practicable after action is taken or warranted as described in Section 12.3-1, Licensure or 12.3-3, Failure to Satisfy Special Appearance, the Medical Executive Council shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Section 12.1-6, Formal Investigation. The Medical Executive Council review and any subsequent hearings and reviews shall not address the propriety of the licensure or DEA action, but instead shall address what, if any, additional action should be taken by VASDHS. There is no need for the Medical

Executive Council to act on automatic suspensions for failures to complete medical records (Section 12.3-4) or comply with government and other third party payor rules and policies (Section 12.3-5).

- b. Practitioners whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable to the state medical board or the National Practitioner Data Bank.

12.3-8 Notice of Automatic Suspension or Action

- a. Special notice of an automatic suspension or action shall be given to the affected individual, and regular notice of the suspension shall be given to the Medical Executive Council, and Director, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member by the Service Chief or Chief of Staff. The wishes of the patient and affected practitioner shall be considered, where feasible, in choosing a substitute member.

12.4 Interview

Interviews shall neither constitute nor be deemed a hearing as described in [Article 13, Hearings and Appellate Reviews](#), shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Council shall be required, at the practitioner's request, to grant an interview only when so specified in this [Article 12, Performance Improvement and Corrective Action](#). In the event an interview is granted, the practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. A record of the matters discussed and the findings resulting from an interview shall be made.

12.5 Confidentiality

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline.

12.6 Reporting

12.6-1 Adverse Actions

In the event a terminated health care professional is deemed to have significantly failed to conform to generally accepted standards of clinical professional practice during employment in such a way as to raise a reasonable concern for the safety of patients, he or she should be reported by the Chief of Staff through the Director to the appropriate state licensing authority and the office of the Medical Inspector of the VA consistent with provisions of [M-2, Pt I, Ch. 34](#). Disclosure of information to state licensing boards regarding practitioners separated from VA service will also be completed under the provisions of [M-2, Part I, Chapter 34](#) and subsequent changes thereto.

Disclosure of information to the NPDB and the HIPDB, through state licensing boards, regarding adverse action against clinical privileges that are in effect for more than 30 days, will follow provisions of [VHA Handbook 1100.17, National Practitioner Data Bank Reports](#), and supplements thereto.

12.6-2 Malpractice Payments

Disclosure of information regarding malpractice payments will follow provisions of VHA Policy on reports to the NPDB as required by [VHA Handbook 1100.17](#) and supplements thereto. Reports to the HIPDB will be made in accordance with current VHA policy.

ARTICLE 13

HEARINGS AND APPELLATE REVIEWS

13.1 General Provisions

13.1-1 Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners and, at the same time, to protect the peer review participants from liability. It is further the intent to establish flexible procedures that do not create burdens that will discourage the Chief of Staff, Director, and Medical Staff as a whole from carrying out peer review. Accordingly, discretion is granted to the Chief of Staff, Director, and Medical Staff to create a hearing process that provides for the least burdensome level of formality in the process and yet still provides a fair review and to interpret these Bylaws in that light. The Chief of Staff, the Director, and their committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and claim all privileges and immunities afforded by the federal laws.

13.2 Grounds for Hearing

Except as otherwise specified in these Bylaws (including those Exceptions to Hearing Rights specified in [Section 13.9](#)), any one or more of the following actions or recommended actions shall be deemed actual or potential adverse action and constitute grounds for a hearing:

13.2-1 Denial of Medical Staff initial applications for membership and/or privileges.

13.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

13.2-3 Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or privileges.

13.2-4 Involuntary imposition of significant consultation or proctoring requirements.

13.2-5 Summary suspension of Medical Staff membership and/or privileges pending corrective action and hearings and appeals procedures.

13.2-6 Any other disciplinary action or recommendation that must be reported to the appropriate State Licensing Board(s) or the National Practitioner Data Bank.

13.3 Requests for Hearing

13.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in [Section 13.2](#), the practitioner shall be given special notice of the recommendation or action and of the right to request a hearing pursuant to [Section 13.3-2](#), Request for Hearing. The notice must state:

- a. What action has been proposed against the practitioner;
- b. Whether the action, if adopted, must be reported;
- c. A brief indication of the reasons for the action or proposed action;
- d. That the practitioner may request a hearing;
- e. That a hearing must be requested within 30 days; and
- f. That the practitioner has the hearing rights described in the Medical Staff Bylaws, including those specified in Section 13.4, Hearing Procedure.

13.3-2 Request for Hearing

- a. The practitioner shall have 30 days following receipt of special notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the Director. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Director within 70 days and shall be given great weight by the Director, although it is not binding on the Director.
- b. The practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.
- c. Any time attorneys will be allowed to represent the parties at a hearing, the hearing officer shall have the discretion to limit the attorneys' role to advising their clients rather than presenting the case.

13.4 Hearing Procedure

13.4-1 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give special notice to the practitioner of the time, place, and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days nor more than 60 days from the date the Chief of Staff received the request for a hearing.

13.4-2 Notice of Charges

Together with the special notice stating the place, time, and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable. A supplemental notice may be issued at any time, provided the practitioner is given sufficient time to prepare to respond.

13.4-3 Hearing Committee

- a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three members who shall

gain no direct benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision maker, or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories or practitioners who are not Medical Staff members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one member who has the same healing arts licensure as the practitioner and who practices the same specialty as the practitioner. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

- b. Alternatively, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned to the Hearing Officer and to the Hearing Committee.
- c. The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

13.4-4 Representation

The practitioner shall have the right, at his or her expense, to attorney representation at the hearing. If the practitioner elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the practitioner elects not to be represented by an attorney in the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney in the hearing. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a licensed practitioner who is not also an attorney at law.

13.4-5 Failure to Appear or Proceed

Failure without good cause of the practitioner to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

13.4-6 Decision of the Hearing Committee

Within 30 days after final adjournment of the hearing, the Hearing Committee shall render a written decision. If the practitioner is currently under suspension, however, the time for the decision and report shall be 15 days after final adjournment. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief of Staff, the Medical Executive Council, the Director, and, by special notice to the practitioner. The report shall contain the Hearing Committee's findings of fact, a conclusion articulating the connection between the evidence produced at the hearing, and the decision reached. Both the practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The

decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or Director review as described in these Bylaws.

13.5 Appeal

13.5-1 Initiating an Appeal

A Medical Staff member subjected to a major adverse action, which is based in whole or in part on a question of professional conduct or competence, may file a written notice of appeal to the VA Disciplinary Appeals Board under the provisions of [VA handbook 5021](#), Part II, Disciplinary Procedures Under Title 38. The member may request a hearing before the Board. Any such request must be submitted in writing and accompany the member's notice of appeal. The appeal must contain:

- a. the appellant's name, address, telephone number, designation of representative (if any)
- b. a copy of the notice of action proposed and decision letter,
- c. a statement that the employee is requesting a hearing before the Board and why the appellant believes the major adverse action taken was in error or should not have been taken, and
- d. a statement describing the expected relief.

13.5-2 The original appeal and the request for hearing, if any, must be submitted to the Under Secretary for Health or designee to be received within 30 days after the date of service of the written decision on the member. Submission of the appeal must be by personal service, facsimile, or certified mail-return receipt requested. A copy of the appeal must be served on the decision official who took the action being appealed and any management representative of record.

13.5-3 Establishing Timeliness of an Appeal

For purposes of computing the 30-day period for filing an appeal, the date of service of the written decision on the member will be determined by the date of receipt by the member of the personal delivery, the signed receipt of certified mail, or presumed to be 5 days after depositing the decision in the U.S. mail if no acknowledged receipt is available.

13.5-4 Representation

The member may be represented by an attorney or other person of their choice.

13.5-5 Determining Jurisdiction

When a Disciplinary Appeals Board is convened to consider an appeal, the Board shall first determine whether the case is properly before it prior to considering the merits of the appeal. The Board shall determine whether the matter appealed is a major adverse action as defined in section A of this appendix, and whether it arises out of or includes a question of professional conduct or competence, and was filed timely. The determination of jurisdiction will be made as soon as practicable. The Board will make a record of its determination.

13.5-6 Disciplinary Appeals Board Decisions

- a. Findings: The Board shall, with respect to each charge appealed, sustain the charge, dismiss the charge, sustain the charge in part, or dismiss the charge in part.
- b. Decision: The Board has full authority to render a decision on an appeal. The Board shall reach a decision within 45 calendar days of completion of the hearing, if a hearing is convened. In any event, a decision will be made by the Board no later than 120 calendar days after the appeal is received by the Under Secretary for Health or designee.
 - 1) If any charge is sustained in whole or in part, the Board shall approve the action as imposed; approve the action with modification, reduction, or exception; or reverse the action.
 - 2) If none of the charges are sustained in whole or in part, the Board will reverse the decision.

13.5-7 Action by the Under Secretary for Health

The Under Secretary for Health shall execute the Board's decision in a timely manner, but in no case later than 90 calendar days after the Board's decision is received by the Under Secretary for Health. Pursuant to the Board's decision, the Under Secretary for Health may order reinstatement, award back pay in accordance with the Back Pay Act , and provide such other remedies as the Board found appropriate relating directly to the proposed action, including expungement of records relating to the action.

- a. However, if the Under Secretary for Health finds a decision of the Board to be clearly contrary to the evidence or unlawful, the Under Secretary for Health may:
 - 1) Reverse the decision of the Board; or
 - 2) Vacate the decision of the Board and remand the matter to the Board for further consideration.
- b. If the decision, while not clearly contrary to the evidence or unlawful, is found to be not justified by the gravity of the charges, the Under Secretary for Health may mitigate the adverse action imposed.
- c. The Under Secretary for Health's execution of a Board's decision, or the mitigated action if appropriate, shall be the final administrative action in the case.

13.6 Confidentiality

To maintain confidentiality in the performance of peer review, disciplinary, and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws.

13.7 Release

By requesting a hearing or appellate review under these Bylaws, a practitioner agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability for the participants in the hearing process.

13.8 Director Committees

In the event the Director should delegate some or all of his or her responsibilities described in this Article 13 to its committees, the Director shall nonetheless retain ultimate authority to accept, reject, modify, or return for further action or hearing the recommendations of the committee.

13.9 Exceptions to Hearing Rights

13.9-1 Exclusive Use Services, Hospital Contract Practitioners

a. Exclusive Use Services

The procedural rights of Article 13 do not apply to a practitioner whose application for Medical Staff membership and privileges was denied or whose privileges were terminated on the basis that the privileges he or she seeks are granted only pursuant to an exclusive use policy. Such practitioners shall have the right, however, to request that the Director review the denial, and the Director shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position to the Director.

b. Hospital Contract Practitioners

The hearing rights of Article 13 do not apply to practitioners who have contracted with VASDHS to provide clinical services. Removal of these practitioners from appointment and of any exclusive privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with VASDHS. The hearing rights of this Article 13 shall apply if an action is taken that must be reported to a State Licensing Board and/or National Practitioner Databank.

13.9-2 Allied Health Professionals

Allied health professional applicants are not entitled to the hearing rights set forth in this Article, however, an AHP whose already-granted privileges are subject to an action that would constitute grounds for a hearing under Section 13.2-2 through 13.2-6 shall be entitled to the procedural rights set forth in this Article 13.

13.9-3 Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current license to practice medicine, dentistry, optometry, clinical psychology, or podiatry, or to meet any of the other basic standards specified in Section 2.1-2 or to file a complete application.

13.9-4 Automatic Suspension or Limitation of Privileges

a. No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 12.3-1.

b. Practitioners whose privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Section 12.3-3), failing to complete medical records (Section 12.3-

4), or failing to comply with particular government or other third party payor rules or policies (Section 12.3-5) are not entitled under Section 12.3-7 to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed 30 days in any 12-month period, and it must be reported to a State Licensing Board.

ARTICLE 14

GENERAL PROVISIONS

14.1 Rules and Policies

15.1-1 Overview and Relation to Bylaws

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Director. Accordingly, the key standards for Medical Staff membership, appointment, reappointment, and privileging are set out in these Bylaws. Additional provisions, including but not limited to administrative procedures for implementing the Medical Staff standards may be set out in Medical Staff or Service rules, or in policies adopted or approved as described below. Upon proper adoption, as described below, all such rules and policies shall be deemed an integral part of the Medical Staff Bylaws.

15.1-2 General Medical Staff Rules

The Medical Staff shall initiate and adopt such rules as it may deem necessary, congruent, and consistent with federal law, VA, and VHA rules and regulations, and shall periodically review and revise its rules to comply with current Medical Staff practice. Recommended changes to the Rules shall be submitted to the Medical Executive Council for review and approval. Following approval by the Medical Executive Council, a rule shall become effective following approval of the Director, which approval shall not be withheld unreasonably, or automatically within 60 days if no action is taken by the Director. If there is a conflict between the Bylaws and the Rules, the Bylaws shall prevail. If there is a conflict between the Bylaws and current VA/VHA rules and regulations, VA/VHA rules and regulations shall prevail.

15.1-3 Service Rules

Subject to the approval of the Medical Executive Council and Director, each Service shall formulate its own rules for conducting its affairs and discharging its responsibilities. Such rules shall be congruent with the Medical Staff Bylaws, hospital policies, VA/VHA rules and regulations, federal law, and current JCAHO standards.

15.2 Authority to Act

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Council may deem appropriate.

ARTICLE 15

ADOPTION AND AMENDMENT OF BYLAWS

15.1 Medical Staff Responsibility and Authority

- 15.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Director, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Executive Leadership Team and hospital administration, in general.
- 15.1-2 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Council.
- 15.1-3 Proposed amendments shall be submitted to the Director for comments before they are distributed to the Medical Staff for a vote. The Director has the right to have his or her comments regarding the proposed amendments circulated with the proposed amendments.

15.2 Methodology

- 15.2-1 Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:
- a. The affirmative vote of a majority of the Medical Staff members voting, provided at least fourteen days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and
 - b. The approval of the Director, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Director in writing, and shall be forwarded to the Chief of Staff and the Medical Executive Council.
 - c. All changes to the Bylaws require action by both the Medical Staff and the Director. Neither may amend unilaterally. Changes become effective upon approval of the Director.

15.3 Adoption

The Director will adopt these Bylaws, together with the appended rules, upon recommendation of the Medical Staff at any regular or special meeting of the Medical Staff at which a quorum is present, or by mail/email vote if no quorum exists, and they shall replace any previous Bylaws and Rules and shall become effective upon approval.

15.4 Technical and Editorial Amendments

The Medical Executive Council shall have the power to adopt such amendments to the Bylaws that are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression or inaccurate cross-references. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Council. After approval, such amendments shall be communicated in writing to the Medical Staff and to the Director. Such amendments would be effective upon adoption by the Medical Executive Council; provided, however, they may be rescinded by vote of the Medical Staff or the Director within 120 days of the date of adoption by the Medical Executive Council. (For purposes of this section, “vote of the Medical Staff” shall mean a majority of the votes cast, provided at least 25% of the voting members of the Medical Staff cast ballots.)

15.5 Inclusions or Exclusions

The Bylaws and Rules and Regulations of the Medical Staff may not contravene those regulations issued by the Department of Veterans Affairs and the Veterans Health Administration, which shall be governing in all instances. All current Medical Center Memoranda are expressly included as adjunct to these Bylaws. Rules of the clinical Services shall not conflict with the Bylaws and Rules of the Medical Staff or the organization.

Adopted by the Medical Staff of the VA San Diego Healthcare System on February 6, 2007.

[CLICK ON THIS LINK TO VIEW SCANNED COPY OF THE ORIGINAL SIGNATURE PAGE INDICATING APPROVAL OF THE 2007 BYLAWS](#)

REVIEWED and RECOMMEND APPROVAL:

Jacqueline G. Parthemore, M.D.
Chief of Staff/Medical Director

Date

APPROVED:

Gary J. Rossio, CHE
Director

Date

VA SAN DIEGO HEALTHCARE SYSTEM



*A Division of VA Desert Pacific
Healthcare Network*

MEDICAL STAFF RULES & REGULATIONS

RULE 1

CATEGORIES OF MEMBERSHIP

1.1 Categories

The medical staff shall consist of the following categories. The rules applicable to each staff category are set forth in the corresponding appendix.

See Appendix

- Active Staff 1A
- Educational Staff, Honorary, and Retired Staff 1B
- Telemedicine Staff 1C

1.2 General Qualifications

Each practitioner who seeks or enjoys staff appointment must continuously satisfy the basic qualifications for membership set forth in the Bylaws and Rules, except those that are specifically waived for a particular category, and the additional qualifications that attach to the staff category to which he or she is assigned. The Director may, after considering the Medical Executive Council's recommendations, waive any qualification in accordance with [Section 2.2-4 - Waiver of Qualifications](#), of the Bylaws.

1.3 Prerogatives and Responsibilities

- 1.3-1 The prerogatives available to a medical staff member depending upon staff category enjoyed are:
- a. Admit patients: Admit patients consistent with approved privileges.
 - b. Eligible for Clinical Privileges: Exercise those clinical privileges that have been approved.
 - c. Vote: Vote on any medical staff matter including Bylaws amendments, and other matters presented at any general or special staff meetings and on matters presented at Service meetings.
 - d. Serve on Committees: Serve on committees and vote on committee matters.

- 1.3-2 The responsibilities which medical staff members will be expected to carry out in addition to the basic responsibilities set forth in the Bylaws, [Section 2.5, Basic Responsibilities of Medical Staff Membership](#), are to:
- a. Medical Staff Functions: Contribute to and participate equitably in staff functions, at the request of a Service Chief, including: contributing to the organizational and administrative activities of the medical staff, such as quality improvement, risk management and utilization management; serving on hospital and medical staff committees; participating in and assisting with the hospital's

medical education programs; proctoring of other practitioners; and fulfilling such other staff functions as may reasonably be required.

- b. Consulting: Consulting with other staff members consistent with his or her delineated privileges.
- c. Attend Meetings: Attend at least the minimum number of staff and Service meetings specified in the Medical Staff Bylaws.
- d. Supervision of House Staff: Directs the care of the patient, provides the appropriate level of house staff supervision, and documents said supervision in the resident progress note within the medical record per [VHA Handbook 1400.1 - Resident Supervision Handbook](#).
- e. Educational Resource for House Staff: Provides insight, mentoring, education, and guidance to house staff on medical or patient care issues.

1.3-3 Prerogatives and Obligations of Staff Categories

The prerogatives and obligations of each staff category are described in the table following.

Appendix 1A ACTIVE STAFF

The Active Staff shall consist of the members who:

1. Are regularly involved in caring for patients or demonstrate, by way of other substantial involvement in medical staff or hospital activities, a genuine concern and interest in the hospital. Regular involvement in patient care shall mean admitting inpatients or outpatients, referring or consulting as appropriate.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
<i>Prerogatives</i>	
Admits, Consults & Refers Patients	Yes
Eligible for Clinical Privileges	Yes
Vote	Yes
Serve as Committee Chair	Yes
Serve on Committee	Yes
<i>Responsibilities</i>	
Medical Staff Functions	Yes
Consulting	Yes
Attend Meetings	Yes
Supervision of House Staff	Yes
Educational Resource for House Staff	Yes
<i>Additional Particular Qualifications</i>	
File Application and Apply for Reappointment	Yes
Active Academic Appointment if supervising trainees	Yes

Appendix 1B

EDUCATIONAL, HONORARY, AND RETIRED STAFF

The Educational Staff shall consist of non-privileged practitioners who possess ability and knowledge that enable them to provide valuable insight, guidance, mentoring and education to house staff in general medical and patient care issues.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
<i>Prerogatives</i>	
Admits, Consults & Refers Patients	No
Eligible for Clinical Privileges	No
Vote	No
Serve as Committee Chair	No
Serve on Committee	Yes
Attend Grand Rounds and other educational meetings	Yes
<i>Responsibilities</i>	
Medical Staff Functions	No
Consulting	No
Attend Meetings	No
Supervision of House Staff	No
Educational Resource for House Staff	Yes
<i>Additional Particular Qualifications</i>	
Services must request appointment to this category and ensures compliance with annual mandatory training requirements	Yes
Provider must agree to assignment to this category by signing MEC-approved memo	Yes
Active Academic Appointment if supervising trainees	Yes

APPENDIX 1C

TELEMEDICINE STAFF

1. Telemedicine Definitions

- a. Distant Site is the location at which the telemedicine equipment is located and from which the Telemedicine Provider delivers his/her patient care services.
- b. Originating Site is the location at which the patient is located.
- c. Telemedicine Provider is the individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider is generally a physician, but other health professionals may also be involved as Telemedicine Providers.

2. Prerogatives and Responsibilities of the Telemedicine Staff

- a. The Telemedicine Staff shall consist of Telemedicine Providers who provide diagnostic or treatment services, from the Distant Site to patients at the Originating Site via telemedicine devices. Telemedicine devices include interactive (involving a real time [synchronous] or near real time [asynchronous] two-way transfer of medical data and information) audio, video, or data communications (but do not include telephone or electronic mail communications) between physician and patient.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	APPLICABLE
<i>Prerogatives</i>	
Admits, Consults & Refers Patients	Yes, with limitations*
Eligible for Clinical Privileges	Yes
Vote	No
Serve as Committee Chair	No
Serve on Committee	Yes
<i>Responsibilities</i>	
Medical Staff Functions	Yes
Consulting	Yes
Attend Meetings	No
Supervision of House Staff	No
Educational Resource for House Staff	Yes
<i>Additional Particular Qualifications</i>	
File Application and Apply for Reappointment	Yes
Active Academic Appointment if supervising trainees	No

RULE 2

APPOINTMENT AND REAPPOINTMENT

2.1 Overview of Process

The following charts summarize the appointment, temporary privileges, and reappointment processes. Details of each step are described in Rules 2.2 through 2.9.

APPOINTMENT

<i>Person or Body</i>	<i>Function</i>	<i>Report to</i>
Service Chief	Requests appointment packet and credentialing	Medical Staff Office
Medical Staff Office	Verify application information	Service (See Rule 2.5)
Service Chief	Review applicant's qualifications vis-à-vis standards developed by Service; recommend appointment and privileges	Professional Standards Board (See Rule 2.7-2)
Professional Standards Board (as delegated decision body for MEC to expedite appointments)	Review Service's recommendation; review applicant's qualifications vis-à-vis medical staff bylaws general standards; recommend appointment and privileges	Medical Executive Council (See Rule 2.7-3)
Medical Executive Council	Review recommendations of Service and Professional Standards Board; recommend appointment and privileges	Director (See Rule 2.7-4)
Director	Review recommendations of the Medical Executive Council; make decision	Final Action (See Rule 2.7-5)

TEMPORARY URGENT PRIVILEGES

<i>Person or Body</i>	<i>Function</i>	<i>Report to</i>
Service Chief	Review applicant's qualifications vis-à-vis standards developed by Service; recommend temporary privileges; document urgent patient care need	Medical Staff Office
Medical Staff Office	Verify key information and give directions for VetPro submission-minimum requirement; report to PSB/MEC at next meeting, and later when ratification takes place; complete verifications in 45 days to ratify appointment	Chief of Staff (See Bylaws-Article 5.5-3d)
Chief of Staff	Review recommendations of Service Chief; recommend temporary privileges	Director (See Bylaws Article 5.5.)
Director	Make decision	Final action (See Bylaws Article 5.5.)

REAPPOINTMENT

<i>Person or Body</i>	<i>Function</i>	<i>Report to</i>
Service	Review applicant’s performance vis-à-vis standards developed by Service; recommend reappointment and privileges	Medical Executive Council (<i>See Rule 2.9-4</i>) or Professional Standards Board
Medical Staff Office	Verify reappointment application information and notify service of missing training and quality assurance information for Service follow up	Service (<i>See Rule 2.9-3</i>)
Section/Service/Chief of Staff	Review and evaluation of verified information and requested privileges, quality assurance data, and training documentation	Medical Executive Council
Medical Executive Council	Review recommendations of Section/Service/Chief of Staff; recommend reappointment and privileges	Director (<i>See Rule 2.9-5</i>) or (<i>See Optional Rule 2.9-5</i>)
Director	Review recommendations of the Medical Executive Council; make decision	Final Action (<i>See Rule 2.9-6</i>)

2.2 Application

- 2.2-1 Applicants for appointment are required to submit, on forms approved by the VHA and/or the VASDHS, a signed Release of Information that allows inquiry about issues pertinent to the matters contained in an Application For Employment. Applicants for membership to the Medical Staff are also required to submit their professional credentials information electronically through the federal credentialing program (VetPro). All information is subject to primary source verification and required clearances before credentialing is considered complete.
- 2.2-2 The application shall include an agreement to abide by the medical staff and hospital bylaws, rules and applicable policies. The application shall request information pertinent to the applicant’s qualifications including, but not limited to, information regarding the applicant’s education, specialty training, professional affiliations, professional and and/or personal references (individuals qualified to provide authoritative reference information regarding training and experience, competence, health status, and/or fulfillment of obligations as a medical staff member within the privileges requested). At least one reference must be provided by the current or most recent employer(s) or institution(s) where clinical privileges are/were held. In the case of individuals just completing residency or fellowship programs, one reference must be from their Program Director. Also required is information regarding possible involvement in professional liability actions (including but not limited to all final judgments or settlements involving the applicant); previously completed or currently pending challenges involving professional licensure, certification or registration (state, territory, or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure, certification or registration; voluntary or involuntary termination, limitation, reduction or loss of medical staff or medical group membership and/or clinical privileges at any other hospital or health facility or

entity; any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and information detailing any prior or pending government agency or third party payor investigation, proceeding or litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to Medicare or Medi-Cal fraud and abuse proceedings or convictions. The application shall also release all persons and entities from any liability that might arise from investigating and/or acting on the application. Additionally, the practitioner shall provide the names and addresses of professional peers who are able to attest to the practitioner's relevant qualifications.

- 2.2-3 U.S. Citizenship. 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 if current visa status and documentation from the Immigration and Naturalization Service or employment authorization can be provided, pursuant to qualifications as outlined in 38 USC7405 and appropriate VHA Directives.
- 2.2-4 Documents required, or which may be requested, in addition to the information or documents listed above include: A copy of current or most recent clinical privileges held, if applicable; verification of the status of licenses for all states in which the applicant has ever held a license; for foreign medical graduates, evidence and verification of the Educational Commission of Foreign Medical Graduates (ECFMG) Certificate; evidence and verification of all board certification(s), if claimed; verification of education credentials used to qualify for appointment (and privileges) including all postgraduate training; query by VASDHS to NPDB, HIPDB, and Federation of State Medical Boards, and the Exclusionary List of the Office of the Inspector General; confirmation of health status; acknowledgement of receipt of Bylaws and employee information on safety and training as well as procedures to follow in the event of an internal and external emergency.

2.2 Physical and Mental Capabilities

- 2.3-1 Obtaining Information
 - a. The application shall request information pertaining to the condition of the applicant's physical and mental health through VetPro Supplemental Information Questions, and Declaration of Health.
 - b. When the Medical Staff Office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities that would impact the ability to perform requested privileges is also requested. This information will also be referred to the Professional Standards Board.
 - c. The Professional Standards Board shall be responsible for investigating any practitioner who has or may have a physical or mental disability that might affect the practitioner's ability to exercise his or her requested privileges in a manner that meets the hospital and medical staff's quality of care standards. This may include one or all of the following:
 - 1) Medical Examination: To ascertain whether the practitioner has a physical or mental disability that might interfere with his or her ability to provide care which meets the hospital and medical staff's quality of care standards.

- 2) Interview: To ascertain the condition of the practitioner and to assess if and how reasonable accommodations can be made.
- d. Any practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her clinical privileges and in meeting quality of care standards should make such limitation immediately known to the Chief of Staff as Chair of the Professional Standards Board. Any such disclosure will be treated with the high degree of confidentiality that attaches to the medical staff's peer review activities.

2.3-2 Review and Reasonable Accommodations

- a. Any practitioner who discloses or manifests a qualified physical or mental disability will have his or her application processed in the usual manner without reference to the condition.
- b. The Professional Standards Board shall not disclose any information regarding any practitioner's qualified physical or mental disability until the Medical Executive Council has determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the practitioner is otherwise qualified, the Professional Standards Board may disclose information it has regarding any physical or mental disabilities and the effect of those on the practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the Medical Executive Council to evaluate what, if any, accommodations may be necessary and feasible. The Professional Standards Board and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.
- c. As required by law, the medical staff and hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities, if the practitioner is otherwise qualified and can perform the essential functions of the staff appointment and privileges in a manner which meets the hospital and medical staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in Article 13, Hearings and Appellate Reviews, of the Bylaws.

2.3 Effect of Application

By applying for or by accepting appointment or reappointment to the medical staff, the applicant:

- 2.4-1 Signifies his or her willingness to appear for interviews in regard to his or her application for appointment.
- 2.4-2 Authorizes medical staff and hospital representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

- 2.4-3 Consents to the inspection and copying, by hospital representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.
- 2.4-4 Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Professional Standards Board through the Medical Staff Office.
- 2.4-5 Releases from any and all liability the medical staff and the hospital and its representatives for their acts performed in connection with evaluating the applicant.
- 2.4-6 Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to hospital representatives.
- 2.4-7 Authorizes and consents to hospital representatives providing other hospitals, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the hospital may have concerning him or her, and releases the hospital and hospital representatives from liability for so doing.
- 2.4-8 Consents to undergo and to release the results of a physical or mental health examination by a practitioner acceptable to the Medical Executive Council, at the applicant's expense, if deemed necessary by the Medical Executive Council.
- 2.4-9 Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the bylaws and these rules.

For purposes of this Rule 2.4, the term "hospital representative" includes the Medical Staff Office, Service/Section Chief, Professional Standards Board, Chief of Staff, Director, and/or council/committee members having responsibility for collecting and evaluating information regarding the applicant's credentials; and any authorized representative or agent of any of the foregoing.

2.5 Verification of Information

The applicant shall fill out and deliver an application form to the Medical Staff Office, which shall seek to verify the information submitted. The application will be deemed complete when all necessary verifications have been obtained, including current license, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank information, Drug Enforcement Administration certificate, if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance and reference letters. Additionally, the Medical Staff Office may seek information from other relevant sources, such as the American Medical Association's Physician Masterfile (for verification of a physician's medical school graduation and residency completion), the American Board of Medical Specialties (for verification of a physician's board certification), the Educational Commission for Foreign Medical Graduates (for verification of a physician's graduation from a foreign medical school), the American Osteopathic Association Physician Database (for pre- and post-doctoral education), and the Federation of State Medical Boards Physician Disciplinary Data Bank (for all actions against a physician's medical license). The Medical Staff Office shall

then transmit the application and all supporting materials to the Chief of the Service in which the applicant seeks privileges and to the Professional Standards Board.

2.6 Incomplete Application

- 2.6-1 If the Medical Staff Office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Medical Staff Office may delay further processing of the application, or may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.
- 2.6-2 If the processing of the application is delayed for more than 60 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected practitioner shall be so informed. He or she shall then be given the opportunity to withdraw his or her application, or to request the continued processing of his or her application. If the applicant does not respond within 30 days, he or she shall be deemed to have voluntarily withdrawn his or her application. If the applicant requests further processing, but then fails to provide or arrange for the provision within 45 days or any other date mutually agreed to when the extension was granted (whichever is later) of the necessary information that the practitioner could obtain using reasonable diligence, the practitioner shall be deemed to have voluntarily withdrawn his or her application.
- 2.6-3 Any application deemed incomplete and withdrawn under this rule may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.

2.7 Action on the Application

- 2.7-1 **Service Action**
Upon receipt, the Service Chief shall review the application and supporting documentation, may personally interview the applicant, and shall transmit to the Professional Standards Board through the Medical Staff Office recommendations as to staff appointment and clinical privileges.
- 2.7-2 **Professional Standards Board Action**
The Professional Standards Board shall review the application, the supporting documentation, the Service's recommendations, and such other information available to it that may be relevant. The Professional Standards Board shall then transmit to the Medical Executive Council its recommendations as to staff appointment and clinical privileges.
- 2.7-3 **Medical Executive Council Action**
a. **Preliminary Recommendation:** At its next regular meeting after receipt of the Professional Standards Board recommendations, the Medical Executive Council shall consider all relevant information available to it. Thereafter, a final recommendation shall be formulated, and the Medical Executive Council shall forward to the Director for his or her recommendations, as follows:

- 1) **Favorable Recommendation:** Favorable recommendations shall be promptly forwarded to the Director together with the application form and its accompanying information and the reports and recommendations of the Service and Professional Standards Board as to staff appointment and clinical privileges to be granted and any special conditions to be attached to the appointment.
- 2) **Adverse Recommendation:** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the practitioner by special notice, and he or she shall be entitled to such procedural rights as may be provided in Bylaws Article 13, Hearings and Appellate Reviews. The Director shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights.

(For the purposes of this section, an adverse recommendation by the Medical Executive Council is as defined in Bylaws Section 13.2.)

- 3) **Deferral:** The Service, Professional Standards Board, or Medical Executive Council may defer its recommendation in order to obtain or clarify information. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and privileges, or for rejection for staff membership.

2.7-4 Director Action

- a. **On Favorable Medical Executive Council Recommendation:** Within 45 days of receipt, the Director shall adopt, reject, or modify a favorable recommendation of the Medical Executive Council, or shall refer the recommendation back to the Medical Executive Council for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Council shall respond. If the Director's action is a ground for a hearing under the Bylaws, Section 13.2, the Director shall promptly inform the applicant by special notice, and he or she shall be entitled to the procedural rights as provided in the Bylaws Article 13, Hearings and Appellate Reviews.
- b. **Without Benefit of Medical Executive Council Recommendation:** If the Director does not receive a Medical Executive Council recommendation within the time specified in [Rule 2.7-6](#) below, he/she may, after giving the Medical Executive Council written notice and a reasonable time to act, take action on his/her own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Director. If the recommendation is a ground for a hearing under the Bylaws, Section 13.2, the Director shall give the applicant special notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the Bylaws Article 13, Hearings and Appellate Reviews, procedural rights before any final adverse action is taken.
- c. **After Procedural Rights:** In the case of an adverse Medical Executive Council recommendation pursuant to [Rule 2.7-3](#) or an adverse Director decision pursuant to Rule 2.7-4a. or 2.7-4b., the Director shall take final action in the matter only after the applicant has exhausted or has waived his or her Bylaws Article 13, Hearings and Appellate Reviews, procedural rights. Action thus taken shall be the

conclusive decision of the Director, except that the Director may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Director shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Director shall make a final decision.

- d. Expedited Review: Per VHA Directive 2002-076, upon receipt of a complete VetPro application for appointment, the Director may approve a one-time-only expedited process for an initial appointment when criteria for that process are met. The Director and Medical Executive Council delegate the authority to render this decision to the Professional Standards Board. The full membership of the Medical Executive Council will review all actions taken by the Professional Standards Board and ratify all positive decisions when verifications are complete. If the Board's decision is adverse to the applicant or if circumstances warrant, the matter under consideration will be referred to the full Medical Executive Council for evaluation and determination of appropriate action. Verification of the following core criteria is essential to the expedited process: current licensure; relevant education and training; certifications, if applicable; two peer references; current competence; ability to perform the privileges requested. Expedited processing is generally not available if:
- 1) The practitioner or Member submits an incomplete application;
 - 2) The Medical Executive Council's final recommendation is adverse in any respect or has any limitations;
 - 3) There is a current challenge or a previously successful challenge to the practitioner's licensure or registration;
 - 4) The practitioner has received an involuntary termination of medical staff membership or some or all privileges at another organization;
 - 5) There has been a final judgment adverse to the practitioner in a professional liability action.

2.7-5 Notice of Final Decision

A decision and notice to appoint shall include:

- a. The staff category to which the applicant is appointed;
- b. The Service and section, if any, to which the practitioner is assigned;
- c. The clinical privileges the practitioner may exercise; and
- d. Any special conditions attached to the appointment.

If the decision is adverse, the notice to the applicant shall be by special notice, as further described at [Article 13.3-1](#) of the Bylaws.

2.7-6 Guidelines for Time of Processing

All individuals and groups shall act on applications in a timely and good faith manner. Except when additional information must be secured, or for other good cause, each application should be processed within the following time guidelines:

REVIEWER	TIME FRAMES FOR REVIEW
Medical Staff Office	45 DAYS after all necessary documentation is received
Service Chief	15 DAYS after receiving application from Medical Staff Office
Professional Standards Board	15 DAYS after receiving application from Service Chief or next scheduled Professional Standards Board, whichever is sooner.
Medical Executive Council	15 DAYS after receiving application from the Professional Standards Board
Director	15 DAYS after receiving application from the Medical Executive Council, except when the hearing and appeal rights of Bylaws Article 13, Hearings and Appellate Reviews, apply

These time periods are guidelines and are not directives that create any rights for a practitioner to have an application processed within these precise periods. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the Chief of Staff or the Director.

2.8 Duration of Appointment

- 2.8-1 Appointments and reappointments to any staff category shall be for a maximum period of two years, and shall be staggered throughout the year so as to enable thorough review of each member.

2.9 Reappointment Process

2.9-1 Schedule for Reappointment

At least 120 days prior to the expiration date of each staff member's term of appointment, the Medical Staff Office shall provide the member with a reappointment packet. Completed reappointment forms and VetPro re-credentialing submissions shall be completed and returned to the Medical Staff Office at least 60 days prior to the expiration date. Failure, without good cause, to complete the necessary reappointment obligations shall result in automatic suspension or resignation as described in [Rule 2.9-8](#).

2.9-2 Content of Reappointment Form

- a. The reappointment application (paper and electronic) shall seek information concerning the changes in the member's qualifications since his or her last review. Specifically, the reappointment application shall request an update of all of the information and certifications requested in the initial appointment application form, as described in [Rule 2.2-2](#), with the exception of that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The application shall also require information as to whether the member requests any change in his or her staff status and/or in his or her clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence that would be

necessary for such privileges to be granted in an initial application and will require the Service Chief's approval.

- b. If the staff member's level of clinical activity at VASDHS is not sufficient to permit a full evaluation of his or her competence to exercise the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at his or her principal institution.

2.9-3 Verification and Collection of Information

The Medical Staff Office shall, in a timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Medical Executive Council, the Professional Standards Board, the Chief of Staff, or Service Chief. The information shall address, without limitation:

- a. Reasonable evidence of current ability to perform privileges that may be requested, including, but not limited to, consideration of the member's professional performance, judgment, clinical or technical skills, and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management, and utilization management activities.
- b. Status of all licenses, registrations, and certifications held.
- c. Participation in relevant continuing education activities.
- d. Level/amount of clinical activity at the hospital.
- e. Sanctions imposed or pending by a hospital, licensing agency, or other professional health care organization, including, but not limited to, previously successful or currently pending challenges to any licensure or registration (state or Drug Enforcement Administration), voluntary or involuntary relinquishment of licensure or registration, or any reduction or loss of privileges at any other hospital.
- f. Health status, including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected practitioner and staff, when requested by the Service Chief or Medical Executive Council, and subject to the standards set forth in [Rule 2.3](#) pertaining to physical and mental capabilities.
- g. Evidence of completion of all VA, VHA, VASDHS mandatory training, certifications, or other organizational obligations as may be required.
- h. Evidence of appropriate oversight and supervision of house staff, and documentation of such supervision in the medical record per [VHA Handbook 1400.1 – Resident Supervision](#).
- i. Timely and accurate completion and preparation of medical records.
- j. Attendance at required medical staff, Service, and committee meetings.
- k. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel, and patients.
- l. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

- m. Compliance with all applicable medical staff and hospital bylaws, rules, and policies.
- n. Professional references from at least two practitioners, neither of which supervise the practitioners, who are familiar with the member's current qualifications by virtue of having recently worked with the member or having recently reviewed the member's cases, neither of whom supervises the practitioner.
- o. Any other pertinent information including the staff member's activities at other hospitals and his or her medical practice outside the hospital.
- p. Information concerning the member from the state licensing board and the federal National Practitioner Data Bank.
- q. Information from other relevant sources, including but not limited to the Federation of State Medical Boards Physician Disciplinary Data Bank.

The Medical Staff office shall transmit the completed reappointment application form and supporting materials to the Chief of the Service to which the staff member belongs.

2.9-4 Service Action

The Service Chief shall review the application and all other relevant available information. The chair may confer with the Service committee, the Section Chief, or the whole Service, if there is no Service committee. He or she shall transmit to the Professional Standards Board his or her written recommendations, which are prepared in accordance with [Rule 2.7-1](#).

2.9-5 Medical Executive Council Action

The Medical Executive Council shall review the Service Chief's recommendations and all other relevant information available to it and shall forward to the Director its favorable recommendations, which are prepared in accordance with [Rule 2.7-3](#).

- a. When the Medical Executive Council recommends adverse action, as defined in the Bylaws, Section 13.2, either with respect to reappointment or clinical privileges, the Chief of Staff shall give the member special notice of the adverse recommendation and of the member's right to request a hearing in the manner specified in Section 13.3. The member shall be entitled to the Article 13, Hearings and Appellate Reviews, procedural rights. The Director shall be informed of, but not take action on, the pending recommendation until the member has exhausted or waived his or her procedural rights.
- b. Thereafter, the procedures specified for members in [Rule 2.7-4](#) (Director action), [Rule 2.7-5](#) (Notice of Final Decision) and those found in the Bylaws shall be followed. The committee may also defer action; however, any deferral must be followed up within 60 days with a recommendation.

2.9-6 Reappointment Recommendations

Reappointment recommendations shall be written and shall specify whether the member's appointment should be renewed; renewed with modified clinical privileges; or terminated. The reason for any adverse recommendation shall be described. The medical staff may require additional proctoring of any clinical

privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

2.9-7 No Extension of Appointment

Except as provided at [Article 4.3-6](#) of the Bylaws, if the reappointment application has not been fully processed before the member's appointment expires, the staff member shall refrain from exercising his or her current membership status and clinical privileges until the reappointment review is complete. If the member is a paid employee of VASDHS and he or she bears the burden of responsibility for this failure, an adverse employment action may occur.

2.9-8 Failure to File Reappointment Application

Failure to file a complete application for reappointment 60 days prior to the expiration of the appointment shall result in the automatic suspension of a practitioner's privileges and prerogatives effective on the date the member's current appointment expires, unless otherwise extended by the Medical Executive Council with the approval of the Director. Prior to suspension, the practitioner will be sent at least one letter by special notice warning of the impending suspension. If an application for reappointment is not submitted, completed as required, before the appointment expires, the member shall be deemed to have resigned his or her membership in the medical staff, effective the date his or her appointment expires. Members who automatically resign under this rule will be processed as new applicants should they wish to reapply.

2.9-9 Relinquishment of Privileges

A staff member who wishes to relinquish or limit particular privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall send written notice to the Chief of Staff and the appropriate Service Chief identifying the particular privileges to be relinquished or limited. A copy of this notice shall be forwarded to the Medical Staff Office for inclusion in the member's credentials file.

References:

- [VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards](#)
- [VHA Directive 2002-076, Expedited Medical Staff Appointment Process](#)
- [VASDHS MCM 11- 56 Credentialing and Privileging/Scope of Practice](#)
- [VASDHS MCM 11E-06, Employee Training Requirements](#)
- [VASDHS MCM 11-38 Credentialing Physicians, Advanced Level Practitioners in the Event of a Disaster](#)
- [VHA Handbook 1100.19, Credentialing and Privileging](#)

RULE 3

STANDARDS OF CONDUCT

3.1 Purpose

The purpose of this Rule is to clarify the provisions of Section 2.7 of the Medical Staff Bylaws, regarding expectations of all practitioners during any and all interactions with persons at the hospital, whether such persons are colleagues, other health care professionals, hospital employees, patients and/or other individuals. This Rule is intended to address conduct that does not meet the professional standards expected of Medical Staff members. In dealing with incidents of inappropriate conduct, the protection of patients, employees, practitioners, and other persons at the hospital is the primary concern. In addition, the well-being of a practitioner whose conduct is in question is also of concern, as is the orderly operation of the hospital.

3.2 Examples of Inappropriate Conduct

Examples of common inappropriate conduct include, but are not limited to, the following¹:

- 3.2-1 Verbal abuse: Verbal abuse is usually in the form of vulgar, profane, or demeaning language, screaming, sarcasm or criticism directed at an individual, having the intent or effect of lowering the recipient's reputation or self-esteem. It is often intimidating to the recipient, and often causes the recipient or others around him or her to become ineffective in performing their responsibilities (e.g., the individuals become afraid or unwilling to question or to communicate concerns, or to notify or involve either the involved practitioner or others when problems occur). This kind of conduct becomes disruptive at the point where it reaches beyond the bounds of fair professional comment or where it seriously impinges on staff morale.
- 3.2-2 Noncommunication: Refusal to communicate with responsible persons can be extremely disruptive in the patient care setting. This kind of behavior often results from individual fighting or feuding, or lack of trust. It becomes disruptive at the point where important information should be communicated, but is not. Closely related are incomplete or ambiguous communications. This becomes disruptive when it diverts patient care resources into having to devote substantial and unnecessary time obtaining follow-up clarification.
- 3.2-3 Refusal to return calls: Refusing to return telephone calls from the facility staff is another form of noncommunication. Often this type of behavior is a result of what a

¹ The foregoing examples are designed to generally discuss and illustrate common problems. They are not exhaustive. Further, it is recognized that in virtually each case cited above, there will be instances where a member's conduct falls outside the literal description of expected behavior, but is nonetheless *not* disruptive. There are circumstances where the exigencies of a situation result in crossing over the lines of acceptable behavior. In most instances, particularly those involving isolated events, corrective action would not be called for. However, repeated or particularly egregious incidents, extending beyond generally recognized standards of behavior, as judged by professional peers, should be subject to such corrective action as deemed necessary to effectively address the particular circumstances, up to and including termination of a practitioner's right to practice in the facility in appropriate cases.

practitioner feels are repeated, inappropriate phone calls from the facility’s staff. However, unless a phone call is returned, the practitioner cannot know the urgency of the matter. The problem becomes disruptive at the point where patient care is placed in unnecessary jeopardy, or when matters that were not initially urgent, and need not have become urgent, become so as a result of a refusal to return calls.

- 3.2-4 Inappropriate communication: It is inappropriate to criticize the facility, its staff, or professional peers outside of official problem-solving and peer review channels. This includes written or verbal derogatory statements to an inappropriate audience, such as patients and families, or statements placed in the medical records of patients. These kinds of communications indiscriminately undermine morale and reputation of the facility and its staff, and contribute to inaccurate perceptions of facility quality.
- 3.2-5 Failure to comply: Failure to comply with the bylaws, policies, and procedures of the medical staff and the facility can be inadvertent or willful. Willful failure to comply – i.e., refusal to comply – with rules becomes disruptive at the point that it places the medical staff or the facility in jeopardy with respect to licensing or accreditation requirements, complying with other applicable laws, or meeting other specific obligations to patients, potential patients, and facility staff. Specific examples include:
- a. Refusing to provide information or otherwise cooperate in the peer review process (e.g., refusing to meet with responsible committee members, refusing to answer reasonable questions relevant to the evaluation of patient care rendered in the facility, especially when coupled with an attitude that the responsible committee has no right to be questioning or examining the matter at hand).
 - b. Refusing to provide information necessary to process the facility’s or a patient’s paperwork. The facility, its patients, and their families have a right to expect timely and thorough compliance with all requirements of the facility, third party payors, regulators, etc., as necessary to assure smooth functioning of the facility in order that patients receive the benefits to which they are entitled.
 - c. Violating confidentiality rules (e.g., disclosing confidential peer review information outside the confines of the formal peer review process).² This has the effect of undermining the peer review process, and jeopardizing important protections that often serve as inducements to assuring ongoing willingness to participate in peer review activities.
 - d. Refusing to comply with established protocols and standards, including but not limited to utilization review standards. Here, it is recognized that from time to time established protocols and standards may not adequately address a particular circumstance, and deviation is necessary in the best interests of patient care. However, in such circumstances, the member will be expected to account for the deviation, and in appropriate circumstances, to work cooperatively and

² This is not to suggest that individual staff members should not speak up if they feel there are shortcomings in other’s performance or in the quality of care being rendered in the facility that are not being effectively responded to by the individual(s) in charge. In such instances, the proper reporting would be to the next higher step in the process (e.g., if a supervisor is not effectively dealing with a matter, the Medical Director or facility administrator should be notified; if the Medical Director is not effectively dealing with a matter, the Board’s designated representative (usually the administrator) should be contacted; if the administrator is not effectively dealing with a matter, the Director should be contacted. All contacts should be factual and professional.

constructively toward any necessary refinements of protocol or standards so as to avoid unnecessary problems in the future. When appropriate, the reason(s) for such deviation should be documented in the patient's chart.

- e. Refusing to participate in or meet medical staff obligations can be disruptive when it reaches the point that the individual's refusal obstructs or significantly impairs the ability of the Medical Staff to perform its delegated responsibilities, all of which are aimed at facilitating quality patient care. This includes attendance of committee meetings to which the member has been assigned.
 - f. Repeatedly abusing or ignoring scheduling and/or timekeeping policies, or reporting late for scheduled clinics, surgeries, and treatments, resulting in unnecessary delays in patient care services being rendered to any patient of the facility.
 - g. Sexual harassment – unwelcome comments or contacts of a sexual nature or characterized by sexual overtones, whether overt or covert, are both illegal and disruptive.
- 3.2-6 Physical abuse: Offensive or nonconsensual physical contact would generally be deemed disruptive, as would intentional damage to facility premises or equipment.
- 3.2-7 Threatening behavior: Threats to another's employment or position, or otherwise designed to intimidate a person from performing his or her designated responsibilities or interfering with his or her well-being are generally disruptive. Examples include threats of litigation against peer review participants or against persons who report concerns in accordance with established reporting channels, and threats to another's physical or emotional safety or property.
- 3.2-8 Combative behavior: Combative behavior refers to that which constantly and aggressively challenges legitimate and generally recognized authority or generally recognized lines of professional interaction and communication. It becomes disruptive at the point that it results in an inability to acknowledge or to deliver constructive comments and criticism.

3.3 Procedures

- 3.3-1 Reporting: Any person may report potentially disruptive conduct in accordance with the hospital's usual reporting procedures. The Medical Staff office or other appropriate recipient of a disruptive conduct complaint shall submit each report to the Chief of Staff and Director for investigation. The Chief of Staff and Director may agree to delegate the investigation and any action to an appropriate committee or investigator. The Chief of Staff and Director may agree to consult with the hospital's Human Resource Management Service or other consultant as appropriate.
- 3.3-2 Investigation
- a. The Chief of Staff and Director, or designated committee or investigator, shall ensure that appropriate documentation of each incident of disruptive conduct is acquired in order to facilitate the investigation process. Such documentation should include:
 - 1) Date and time of the reported disruptive behavior.

- 2) A statement by the reporting individual of whether the behavior involved a patient in any way, and, if so, information identifying the patient involved.
 - 3) The reporter's account of the circumstances that precipitated the situation.
 - 4) A factual and objective description of the reported disruptive behavior (e.g., Report of Contact).
 - 5) To the extent known to the reporter, the consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations.
 - 6) A record of any action taken to address the situation, prior to the investigation as required by the Code of Conduct, including the date, time, place, action and name(s) of those taking such an action.
- b. The Chief of Staff and Director, or designated committee, shall conduct an appropriate investigation for each matter reported.
 - c. If the report of inappropriate conduct is anonymous, then, the Chief of Staff and Director, or designated committee, shall exercise discretion as to whether or not to investigate the matter.
 - d. The investigation shall take place within 14 calendar days from receipt of a report of inappropriate conduct.

3.3-3 Action

- a. **Unfounded Report:** Based on the investigation, the Chief of Staff, Director, or designee shall dismiss any unfounded report by providing a written explanation of the evidence supporting this conclusion. The report shall be maintained by Human Resources Service in the Medical Staff member's Official Personnel File (OPF) with the original complaint with a copy to their peer review file. The individual who initiated the report may be notified of the decision.
- b. **Confirmed Report:** A confirmed report will be addressed as follows: The Chief of Staff and Director, or designee, shall consider a number of variables to determine how best to address each incident of disruptive behavior. These variables shall include, but not be limited to:
 - 1) Degree of disruptiveness
 - 2) Number of incidents (i.e., pattern of disruptive behavior over time)
 - 3) Length of time between incidents of disruptive behavior, if multiple incidents have occurred.
 - 4) Whether or not the conduct violated facility policy.
- c. **Plan for Addressing Disruptive Behavior:** Relying on the variables described above as well as the overall intent of [Article 2.6](#) of the Medical Staff Bylaws, the Chief of Staff, and Director, Human Resource Management Service's guidance, shall document a plan for addressing the disruptive behavior. The copy of the plan shall be included in the individual's OPF. The plan shall include item (1) below and may include any portion or all of items (2) and (3) below:
 - 1) The Director, or designee, shall send a letter to the offending individual that describes the inappropriate conduct, explains that the behavior is in violation of [Article 2.6](#) of the Medical Staff Bylaws, notes any patient care or hospital

operations implications, explains why the behavior in question is inappropriate, encourages the individual to be more thoughtful or careful in the future, invites the individual to respond, and makes clear that attempts to confront, intimidate, or otherwise retaliate against the individuals who reported the behavior in question is a violation of this Rule and grounds for further disciplinary action. A copy of [Article 2.6](#) of the Bylaws and this Rule should be included with the letter. Documentation of both the letter and the individual's response should be included in the individual's file.

- 2) The Chief of Staff, Director, the designated committee, and/or appropriate Chief of the Service to which the offender is assigned, shall initiate a discussion with the offending individual to discuss the inappropriateness of his or her behavior and require that such behavior cease. A copy of [Article 2.6](#) the Medical Staff Bylaws and this Rule may be hand delivered to the offending individual and he or she should be advised that the Medical Staff requires compliance with the Bylaws and other VASDHS policies related to conduct. Each individual or a designated member of a group, (if the group meets with the offending individual), shall send a follow-up letter documenting the content of the discussion and any specific actions the offending individual has agreed to perform. The offending individual should be invited to respond. This letter and any response will be included in the individual's file.
- 3) The plan may incorporate additional components, including, but not limited to:
 - i) Warning the offending individual that failure to abide by the terms of the Standards of Conduct shall be grounds for disciplinary action, including but not limited to suspension and/or actual termination of Medical Staff membership.
 - ii) Notifying one or all of the following individuals of the member's disruptive behavior and any relevant history relating to the member: Chief of Staff, Medical Executive Council, and Director.
 - iii) Requiring the offending individual to agree to specific corrective actions aimed at eliminating that individual's disruptive behavior. Suggested actions are counseling, leave of absence, written apologies, courses or programs specific to the behavior trait (i.e., anger or stress management), or requiring the offending individual to sign a behavior modification contract. The Chief of Staff, Director, or designated committee shall document any corrective action and require the offending individual to sign his or her acceptance of this plan. The plan may clearly delineate the consequences for the offending individual not successfully completing the agreed upon corrective action.
 - iv) In appropriate circumstances, the plan may provide for immediate suspension and/or action to terminate Medical Staff membership without need of further warning or counseling.

3.3-4 Final Warning: If the Chief of Staff, Director, or designated committee determines that the plan has been unsuccessful, the Medical Executive Council shall be informed

in writing of the offending individual's disruptive behavior, including any relevant history regarding this behavior, and advise the Medical Executive Council to proceed with a final warning. If the Medical Executive Council determines that the offending individual deserves a final warning, the Medical Executive Council Chair/designee (or the Chief of Staff/designee or Director/designee) shall meet with and advise the offending individual that the disruptive behavior in question is intolerable and must stop. The Chief of Staff/designee or Director/designee will inform the individual that a single recurrence of disruptive behavior shall be sufficient cause to result in his/her suspension and/or termination of Medical Staff membership. This meeting shall not be a discussion, but rather will constitute the offending individual's final warning. The offender will also receive a follow-up letter that reiterates the final warning and the consequence of suspension and possible termination of Medical Staff membership and privileges.

- 3.3-5 Suspension: If after the final warning the offending individual engages in disruptive behavior that is deemed to require intervention, the individual's Medical Staff membership and privileges shall be subject to suspension consistent with the terms of the Medical Staff Bylaws and VA, VHA, VASDHS policies and procedures. Additional action may also be taken at this time. Action may be taken to revoke the individual's membership and privileges. The individual may also be found ineligible to reapply to the Medical Staff for a period of at least two years.
- 3.3-6 Consequences of a Member's Failure to Comply with the Standards of Conduct: Members who do not act in accordance with the Standards of Conduct shall be subject to corrective action and/or disciplinary action, up to and including termination of membership and privileges, pursuant to the Bylaws. Any recommendation to restrict, or restriction of Member's membership or privileges shall entitle the member to hearing procedures set forth in the Bylaws.

References:

VASDHS MCM 07B-10, Workplace Violence Response Policy
VASDHS MCM 00-16, Standards of Conduct

RULE 4

COMMITTEES

4.1 Committees

The medical staff hereby establishes the following committees or councils. The rules applicable to standing committees under the Medical Executive Council are defined in the Bylaws.

Ambulatory Care Executive Council

Cancer Committee ([MCM 11-03](#))

Critical Care Committee ([MCM 11-17](#))

Education Committee

Environment of Care Oversight Committee ([MCM 00-09](#))

Geriatrics Council

Infection Control Committee ([MCM 11-09](#) & [11-53](#))

Informatics Advisory Council

Medical Records Committee ([MCM 11-12](#))

Mental Health Council

Pain Council

Patient Rights and Organizational Ethics Council

Peer Review Committee ([MCM 11-55](#))

Performance Improvement Council

Pharmacy and Therapeutics Committee ([MCM 11-67](#))

Procedures and Anesthesia Care Council

Professional Standards Board(s) ([MCM 11-01](#))

Rehabilitation Council

Research & Development Committee ([MCM 151-01](#))

Transfusion Review Committee ([MCM 11-33](#))

Veterans & Employee Satisfaction Council ([MCM 00-79](#))

RULE 5

SERVICES

5.1 Service Functions

Each Service (also known as department), through its officers and established committees, is responsible for the quality of care within the Service, and for the effective performance of the following as it relates to the members and AHPs practicing within the Service:

- 5.1-1 Continuous surveillance of professional performance of all members and AHPs exercising privileges in the Service and continuous assessment and improvement of the quality of care, treatment, and services (including periodic demonstrations of ability), consistent with guidelines developed by the committees responsible for quality improvement, utilization review, education, and medical records, and by the Medical Executive Council.
- 5.1-2 Credentials review, consistent with guidelines developed by the Professional Standards Board and the Medical Executive Council.
- 5.1-3 Recommendation to the Medical Executive Council criteria for the granting of clinical privileges, including but not limited to any privileges that may be appropriately performed by AHPs or via telemedicine, and the performance of specified services within the Service.
- 5.1-4 Corrective action, when indicated, in accordance with Bylaws [Article 12, Performance Improvement and Corrective Action](#).
- 5.1-5 Orientations and continuing education consistent with guidelines developed by the committee responsible for continuing medical education and the Medical Executive Council.
- 5.1-6 Maintaining records of meetings that include pertinent decisions, conclusions, recommendations or actions, and evaluation of actions taken. Said records are forwarded timely to the Chief of Staff for review and signature.
- 5.1-7 Regular review of Medical Staff and other committee minutes, as appropriate, and initiation of action in response to issues specific to the service.
- 5.1-8 Planning and execution of appropriate actions in response to facility, network, and organizational initiatives, directives, performance measures, and mandates.

5.2 Service Chief Qualifications

Each Service Chief shall:

- 5.2-1 Be board certified in his or her appropriate specialty.
- 5.2-2 Be appointed by the Director based upon the recommendation of a search committee, the Medical Executive Council, the Professional Standards Board, the Affiliation Partnership Council, the VISN 22 Director, and the VA Central Office program official, as may be required by VHA regulations.
- 5.2-3 Have demonstrated clinical competence in his or her field of practice sufficient to maintain the respect of the members of his or her Service.

- 5.2-4 Have an understanding of the purposes and functions of the staff organization and a demonstrated willingness to promote patient safety over all other concerns.
- 5.2-5 Have an understanding of and willingness to work with the hospital toward attaining its lawful and reasonable goals.
- 5.2-6 Have an ability to work with and motivate others to achieve the objectives of the medical staff organization in the context of the hospital's lawful and reasonable objectives.
- 5.2-7 Be (and remain during tenure in office) an active staff member in good standing.
- 5.2-8 Not have any undisclosed conflict of interest.

5.3 Responsibilities of Service Chiefs

- 5.3-1 Each Service Chief shall be responsible for:
 - a. All Service clinical activities.
 - b. All administrative activities of the Service (unless otherwise provided for by the hospital).
 - c. Integrating the Service into the primary functions of the organization.
 - d. Coordinating and integrating inter-departmental and intra-departmental services.
 - e. Developing and implementing policies and procedures that guide and support the provision of services in the department, and ensuring that such policies/procedures are reviewed and updated timely and contents are congruent with JCAHO and other accrediting body standards, local policies, and VA/VHA directives, rules, and regulations.
 - f. Recommending qualified and competent persons to provide care in the Service.
 - g. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Service.
 - h. Recommending the criteria for clinical privileges in the Service.
 - i. Evaluating the qualifications and competence of practitioners and allied health professionals (AHPs) who provide patient care within the purview of the Service.
 - j. Recommending appointment and clinical privileges for each practitioner and AHP desiring to exercise privileges in the Service.
 - k. Maintaining quality control programs, as appropriate and in coordination with the Performance Improvement Council.
 - l. Continuously assessing and improving the quality of care provided in the Service, including, but not limited to access, efficiency, effectiveness, satisfaction, staffing, appropriateness of care and treatment, and clinical/professional performance of all staff in the Service.
 - m. Overseeing the orientation, continuing education, and all mandatory training requirements of all persons in the Service
 - n. Planning and budget review consistent with guidelines developed by the Medical Executive Council. This includes making recommendations regarding

- space, equipment, staffing, and other resources needed to ensure high quality and consist patient care.
- o. Making recommendations to the relevant hospital authority with respect to off-site sources needed for patient care services not provided by the Service or the hospital.
 - p. Chairing all Service meetings.
 - q. Serving as an ex officio member of all committees of his or her Service and attending such committee meetings as necessary for adequate information flow.
 - r. Assuring that records of performance are maintained and updated timely for all members of the Service.
 - s. Reporting on activities of supervised medical staff to the Director when called upon to do so by the Chief of Staff or the Director.
 - t. Consistently attending and participating as a member of the Medical Executive Council.
 - u. Performing such additional responsibilities as may be delegated to him or her by the Medical Executive Council or the Chief of Staff.

References:

[VHA Manual M-1, Part I, Chapter 26, Change 102](#)
38 USC 7401, 7461
[VHA Manual M-2, Parts I, II and Supplements](#)
[VHA Manual M-2, Programs Guides](#)
[MCM 00-24 Medical Executive Council](#)
[MCM 11-01 Professional Standards Board](#)
[MCM 11-06 Hospital Ethics Advisory Team \(HEAT\)](#)
[MCM 11-65 Setting-Specific Privileges and Performance of Procedures](#)

RULE 6

ALLIED HEALTH PROFESSIONALS

6.1 Overview

- 6.1-1 The credentialing process for allied health professionals (AHPs) is similar to that for credentialing medical staff members. However, the Professional Standards Board that is responsible for the professional practice of a particular type of AHP (e.g., Nurse Professional Standards Board) may be different from the Medical Staff Professional Standards Board, and is responsible for overseeing the credentialing of AHPs. The credentialing process for AHPs is summarized at Rule 6.3, below.
- 6.1-2 Rule 6.4 reflects the basic requirements that all AHPs must meet.
- 6.1-3 Also, the clinical Service in which the AHP will exercise privileges has a role in establishing criteria for the exercise of specific privileges in that Service, and in evaluating whether the particular applicant meets the established criteria. The Services also have the responsibility for generally supervising AHPs in their Service.
- 6.1-4 Until the AHP has been granted privileges and assigned to a Service, an AHP should not be practicing within the hospital.

6.2 Categories of AHPs Eligible to Apply for Practice Privileges

- 6.2-1 The types of AHPs allowed to practice in the hospital will be ultimately determined by the Director, based upon the comments of the Medical Executive Council and such other information as may be available to the Director.
- 6.2-2 The types of AHPs currently eligible to apply for practice privileges are:
 - a. Clinical Nurse Specialists
 - b. Nurse Anesthetists
 - c. Nurse Practitioners
 - d. Physician's Assistants
 - e. Clinical Pharmacists
- 6.2-3 When an AHP in a category that has not been approved as eligible to apply for clinical privileges under Article VI of the Bylaws requests privileges, the Medical Staff Office and/or Human Resources Management Service may begin to process an application at the same time the request for recognition of the profession is processed, however, no right to practice in the hospital is thereby created or implied.

6.3 Processing the Application

- 6.3-1 Applications shall be submitted and processed in a manner parallel to that specified for medical staff applicants in [Rule 2](#), Appointment and Reappointment.

- 6.3-2 Once the application is determined to be complete, it will be forwarded to the appropriate Professional Standards Board for consideration. The Professional Standards Board may meet with the applicant and the sponsoring or supervising practitioner (if applicable). The Professional Standards Board shall evaluate the AHP based upon the standards set forth in [Rules 2](#) and [6.4](#), below. The Professional Standards Board will also ascertain that appropriate monitoring mechanisms are in place in the Service. Whenever possible, the Professional Standards Board shall include practitioners in the same AHP category when conducting its evaluation. The Professional Standards Board shall forward its recommendations to the Service to which the AHP would be assigned.
- 6.3-3 Upon receipt of an AHP application from the Professional Standards Board, the Service Chief shall evaluate the AHP based upon the standards set forth in [Rules 2](#) and [6.4](#), below. The Service Chief or his or her designee may meet with the AHP as well as the sponsoring or supervising practitioner (if applicable) to further investigate the AHP's request for privileges. The Service Chief will make a recommendation to the Medical Executive Council regarding the applicant's qualifications to exercise the requested privileges.
- 6.3-4 Thereafter, the application shall be processed by the Medical Executive Council and Director in accordance with the procedures set forth in Rule [2.7-3](#) through [2.7-6](#).

6.4 Credentialing Criteria

6.4-1 Basic Requirements

- a. The applicant must belong to an AHP category approved for practice in the hospital by the Director.
- b. If required by law, the applicant must hold a current, unrestricted state license or certificate.
- c. In addition, hospital independent contractors shall meet all conditions of their contract with the hospital.
- d. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the hospital, and that he or she is qualified to exercise clinical privileges within the hospital.
- e. The applicant must submit a minimum of two references from either licensed physicians or adequately trained professionals in the appropriate field and who are familiar with his or her professional work and have demonstrated competency.
- f. The applicant must be determined, on the basis of documented references, to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to adversely affect patient care, to be willing to participate in and properly discharge responsibilities as determined by the medical staff.

6.4-2 Specific Requirements

In addition to meeting the general requirements outlined above, applicants must meet any specific requirements established for his or her category of AHP, as set forth in the applicable appendix:

See Appendix:

- | | |
|-------------------------------|----|
| a. Clinical Nurse Specialists | 6A |
| b. Nurse Anesthetists | 6B |
| c. Nurse Practitioners | 6C |
| d. Physician's Assistants | 6D |

6.5 Duration of Appointment and Reappointment

- 6.5-1 AHPs shall be granted practice privileges for no more than 24 months. Reappointments to the AHP staff shall be processed every other year, in a parallel manner to that specified in the [Rule 2](#) for medical staff members.
- 6.5-2 Applications for renewal of the AHP's privilege and the supervising practitioner's approval must be completed by the AHP and supervising practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in the Medical Staff Rules.

6.6 Observation – For Review & Comment

- 6.6-1 All new AHPs shall be subject to evaluation as defined in Service rules or policy.
- 6.6-2 Each Service shall be responsible to establish observation programs appropriate to each category of AHP granted privileges within that Service. The Service shall determine the appropriate frequency and methods of proctoring and/or initial evaluation, which may include concurrent or retrospective chart review or consultations. AHPs exercising surgery or anesthesia practice privileges shall be observed during surgery.
- 6.6-3 The evaluator may be a member in good standing of the medical staff who exercises appropriate clinical privileges; however, in appropriate circumstances, the Service Chief may assign an appropriately credentialed AHP to serve as the evaluator.
- 6.6-4 The Director may approve alternative observation procedures for AHPs.

6.7 General

6.7-1 Duties

Upon appointment, each AHP shall be expected to:

- a. Consistent with the privileges granted to him or her, exercise independent judgment within his or her areas of competence and, if applicable, within the limits of an approved standardized procedure, provided that a medical staff member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.
- b. Participate directly in the management of patients to the extent authorized by his or her license, certificate, other legal credentials, any applicable standardized procedures, and by the privileges granted by the Director.

- c. Write orders to the extent established by any applicable medical staff or Service policies, rules, or standardized procedures and consistent with privileges granted to him or her.
- d. Record reports and progress notes on patient charts to the extent determined by the appropriate Service, and in accordance with any applicable standardized procedures.
- e. Assure that records are countersigned as appropriate.
- f. Consistent with the privileges granted to him or her, perform consultations as requested by a medical staff member.
- g. Comply with all medical staff and hospital bylaws, rules, and policies.

6.7-2 Prerogatives and Status

AHPs are not members of the medical staff, and hence shall not be entitled to vote on medical staff matters. They are expected to attend and actively participate in the clinical meetings of their respective Services, to the extent consistent with Service rules.

6.8 Standardized Procedures

6.8-1 Definition

Standardized procedures means the written policies and protocols for the performance of standardized procedure functions, and which have been developed in accordance with the requirements of state law.

6.8-1 Functions Requiring Standardized Procedures

Standardized procedures are required whenever any registered nurse (including, but not by way of limitation, Nurse Anesthetists, Nurse Practitioners and Clinical Nurse Specialists) practices beyond the scope of practice taught in the basic curriculum for registered nurses as contemplated by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

6.8-3 Development of Standardized Procedures

- a. Standardized procedures may be initiated by the appropriate Service, the affected AHPs, or sponsoring or supervising practitioners.
- b. The appropriate Professional Standards Board is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Representatives of the category of AHPs that will be practicing pursuant to the standardized procedures shall be involved in developing the standardized procedures.
- c. Each standardized procedure shall:
 - 1) Be in writing and show the date or dates of approval by the appropriate Professional Standards Board.
 - 2) Specify which standardized procedure functions each AHP may perform and under what circumstances.
 - 3) State any specific requirements that are to be followed by AHPs in performing particular standardized procedure functions.

- 4) Specify any experience, training and/or education requirements for performance of standardized procedure functions.
- 5) Establish a method for initial and continuing evaluation of the competence of those AHPs authorized to perform standardized procedure functions.
- 6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
- 7) Specify the nature and scope of review and/or supervision required for performance of standardized procedure functions; for example, whether the functions must be performed under the immediate supervision of a physician.
- 8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.
- 9) State the limitations on settings or Services, if any, in which standardized procedure functions may be performed.
- 10) Specify patient recordkeeping requirements.
- 11) Provide for a method of periodic review of the standardized procedures.

Standardized procedures shall be reviewed by the Service, and then must be approved by the appropriate Professional Standards Board, the Medical Executive Council, and the Director.

References:

[MCM 11-01 - Professional Standards Board](#)
[MCM 11-56 Credentialing and Privileging/Scope Of Practice](#)

RULE 7

ELECTRONIC INFORMATION SYSTEMS AND SECURITY

7.1 Overview

- 7.1-1 The hospital utilizes an electronic medical record system for care documentation and provider orders. Except in the event of computer failure or for exceptions as provided in specific policies and procedures, all patient care documentation shall be entered into the electronic medical record.
- 7.1-2 Members of the Medical Staff are required to have active accounts that allow access to the computerized patient record system (CPRS). Access codes (e.g., access and verify codes, network codes, electronic signature codes) are unique to the individual user and may not be shared or disclosed for any reason. Failure to safeguard codes or utilizing another user's codes represents a violation of information security that may result in disciplinary action including possible suspension or loss of medical staff privileges.
- 7.1-3 A health record includes the electronic medical record and the paper record, combined, and is also known as the legal health record. A health record can be comprised of two divisions, which are the:
- a. Health Record. This is the documentation of all types of health care services provided to an individual, in any aspect of health care delivery. It includes individually identifiable data, in any medium, collected and directly used in and/or for documenting health care. The term includes records of care in any health-related setting used by health care professionals while providing patient care services, to review patient data or document their own observations, actions, or instructions. The health record includes all handwritten and computerized components of the documentation.
 - b. Administrative Record. This is an official record pertaining to the administrative aspects involved in the care of a patient, including demographics, eligibility, billing, correspondence, and other business-related aspects.

References:

[MCM ITS-13 Automated Information System \(AIS\) Security Policy](#)
[VHA Handbook 1907.01-Health Information Management and Health Records](#)

RULE 8

PATIENT RIGHTS AND RESPONSIBILITIES

8.1 Overview

- 8.1-1 The hospital and its Medical Staff support the rights and responsibilities of each patient as an integral part of the health care team.
- 8.1-2 Specific information related to patient rights and responsibilities can be found in [MCM 00-18](#).

8.2 Advance Directive

- 8.2-1 It is hospital policy to follow a patient's or their surrogate decision-maker's choice in health care decisions, including the right to request that life-sustaining treatment be withheld or withdrawn. Specifics as to the hospital's policy related to withdrawal of life-sustaining therapy can be found in [MCM 11-05](#).
- 8.2-2 Specifics as to advance directives can be found in [MCM 11-37](#).

8.3 Informed Consent

- 8.3-1 The consent of a patient shall be obtained prior to the performance of specific procedures. Informed consent implies an understanding by the patient of his or her disease, its consequences, the planned procedure, the reason for the procedure, the consequences that may reasonably be expected if the procedure is or is not performed, the risk(s) of either undergoing or refusing the planned procedure, and the alternative treatments that may be available. Pre-procedure counseling and a description of the informed consent process will be documented in an Informed Consent Progress Note in CPRS by the consulting provider. A physician will include a discussion of the choice of anesthesia and the options available should blood transfusion be required, as well as the risk of refusing transfusion. Additional requirements and details concerning the hospital's informed consent policy can be found in [MCM 11-43 – Informed Consent](#).

RULE 9

GENERAL RESPONSIBILITY FOR CARE

9.1 Conduct of Care

- 9.1-1 A credentialed and privileged member of the Medical Staff will be responsible for the management of every patient throughout the continuum of care.
- 9.1-2 A consistent standard of care will be provided to all patients throughout VASDHS.
- 9.1-3 When a member of the medical staff does not believe he/she is able to provide an aspect/episode of care for a patient for reasons of personal conflict in cultural values, ethical standards, or religious beliefs, the individual may request of his or her Service Chief that another member of the medical staff assume responsibility for that aspect/episode of care as defined in [MCM 05-11 "Employee Rights Relating to Patient Care."](#)

9.2 Emergency Services

- 9.2-1 The hospital provides emergency services, which do not include acute Level I trauma care nor participation in community emergency services (i.e., accepting patients from community ambulances for acute care). Physician staffing shall be consistent with this. Obstetrical and pediatric patients will be triaged, stabilized, and appropriately referred as will all other non-veteran patients who present for care.
- 9.2-2 Provision of emergency care will take place in the Urgent Care Center (UCC), also referred to as the Admission/Triage Area, or, if appropriate, in the Psychiatric Emergency Care (PEC) area.
- 9.2-3 Providers of emergency care will evaluate any applicant regarding the need for emergent treatment or hospitalization.
- 9.2-4 Providers of emergency services will provide for the disposition of patients who do not require urgent/emergent care or who are not legally eligible for non-emergent care at the hospital, referring them, if necessary, to community facilities with their consent.

9.3 Admissions

- 9.3-1 Only members of the Medical Staff, to whom admitting privileges are extended, may admit patients to inpatient beds. House staff, when acting on behalf of a supervising member of the Medical Staff may direct the admission of patients.
- 9.3-2 Nurse practitioners, physician assistants, dentists, and podiatrists may provide initial comprehensive, or specialty physical examination, as designated in their scope of practice, privileges, or assignments as a house officer. In keeping with the policies of each unit, all patients admitted to inpatient beds, outpatient surgery, or for a 23-hour observation stay, will be evaluated by a qualified physician or member of the Medical Staff with appropriate clinical privileges or scope of practice to provide a history, physical examination, and assessment. Evaluations provided under a scope of practice will be reviewed and co-signed by a privileged practitioner, as will house

staff evaluations. Admission evaluations provided under scope of practice or by a house officer will be co-signed by a privileged member of the Medical Staff.

- 9.3-3 Lodgers will not be evaluated as above, but assessed according to the hospital Lodger Program Scope of Service.

9.4 Admission History and Physical Examinations (H&Ps)

- 9.4-1 A qualified physician, dentist, podiatrist, NP, or PA must perform a History and Physical Examination (H&P) not more than 30 days prior to admission. The H&P will be completed promptly, but not more than 24 hours after admission, and, if completed by a member of the housestaff, or a practitioner functioning under Scopes/Standards of practice, will be reviewed and co-signed by a privileged member of the medical staff by the end of the calendar day following admission. The member of the medical staff signing an H&P written by a PA, NP, or any member of the staff who does not have privileges to admit, will write a separate addendum to the H&P or progress note, identifying himself or herself as the attending, documenting pertinent history and physical information and concurring with the diagnosis and treatment plan. H&Ps performed prior to admission for same day surgery, ambulatory surgery, or 23-hour observation stay, will be updated and/or revised as necessitated by any change in patient status. The assessment by the medical staff will be documented in an MEC approved electronic note (using the title “Physician’s Admission H&P”) in which all applicable elements will be completed. (Also see [Medical Records, Rule 12](#))
- 9.4-2 If a patient is readmitted within 30 days of discharge, their prior H&P may be referred to and information documenting any change in the history or physical exam that has occurred in the interim will be noted in the appropriate sections of the admission H&P note. If there has been no interim change, the admission note will state this. In all instances, the electronic title “Physician’s Admission H&P” will be used.
- 9.4-3 Each patient admitted to the Medical Center will have only those diagnostic tests deemed necessary and appropriate by his/her attending physician.
- 9.4-4 The attending physician will document concurrence in specific aspects of patient care, other than the H&P or the discharge summary, in an original note, or by co-signature of housestaff note, or by housestaff notation of concurrence by an attending physician in their progress note. Details related to procedural requirements of supervision and documentation of supervision can be found in [VHA Handbook 1400.1 - Resident Supervision](#) including any updates or supplements thereto and [MCM 11E-01](#). The attending physician/supervising practitioner will sign the discharge summary and operation report.

9.5 Transfers

- 9.5-1 When VASDHS has the means to provide adequate care for eligible veterans or to provide emergency care for patients who are not veterans (humanitarian care), arbitrary transfer to another hospital is prohibited.
- 9.5-2 No transfer from an inpatient status to another hospital will take place without the consent of the attending physician on whose service the patient resides. He/she will obtain the COS/MD’s approval for such a transfer. Issues such as the availability of necessary services within VASDHS or other VA facilities, as well as the cost of the

service versus the benefit to the patient, will be considered in transfer decisions. Whenever possible, a stable inpatient who needs care that is not available at VASDHS will be referred to another VA facility which can provide the needed service and which is willing to accept the patient in transfer. If such a VA facility is not available, or the patient is deemed unable to be transported to another VA facility, transfer to a community/affiliate hospital with needed services will be sought and arranged with approval of the COS/MD, or his/her designee.

- 9.5-3 Once a decision is made to transfer, the attending physician will determine the mode of transfer and the necessity for qualified medical staff to accompany the patient. Copies of all medical information will accompany the patient. The Patient Care Services section of Nursing Service will assist in the transfer, as available, contacting the accepting hospital, arranging transportation, and assisting in other administrative matters. The VASDHS transferring physician has an obligation to discuss the patient being transferred with the accepting/admitting physician at the accepting facility and to obtain the patient's or his/her surrogate's consent for transfer.
- 9.5-4 Transfers of non-emergent, non-veteran outpatients to non-VA facilities will take place only after contact has been made with a care provider at the other medical center who is authorized to accept the patient and agrees to do so. The specifics of paragraph 9.5-2 above will apply in such a transfer.
- 9.5-5 Transfer of an inpatient between treating specialties, levels of care, or attending physicians requires concurrence by the transferring and accepting attendings. The attending will document acceptance of the patient and concur in the care plan by original transfer progress note or co-signature of the housestaff note.
- 9.5-6 In an emergency, an impending emergency, or when it is necessary to evacuate patients from one section of the VASDHS to another, or to otherwise evacuate the medical center premises as a result of a natural disaster, or for other reasons, the COS/MD or his/her designee will oversee the movement of patients with the concurrence of the Director.

9.6 Consultations

- 9.6-1 Each consultant will be qualified to give an opinion in the field in which his/her opinion is sought and will possess privileges in said field.
- 9.6-2 All consultation requests must be submitted through CPRS with sufficient detail to justify the request. Responses to requests for consultations by members of the Medical Staff require complete documentation and will reflect pertinent examination of the patient and review of the patient record. When fellows and other housestaff participate in consultations, the consultation note will reflect discussion with the attending physician or will be co-signed by the attending physician. Consultations for hospitalized patients will result in a timely assessment and documentation. With the consent of the requesting physician, such a consult can be delayed for cause, but not for more than 72 hours. (Cause includes such an event as availability of a specific consultant who is solely able to provide the consultation, etc.)
- 9.6-3 Emergent or urgent inpatient consultations will be completed in a timely manner but not later than within one (1) working day of receipt of the request. In addition to submission through CPRS, emergent consultation requests will include physician-to-physician communication.
- 9.6-4 Consultations may be sought under, but not limited to, the following circumstances:

- a. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed, or
- b. The care is complicated with respect to available diagnostic or therapeutic options, or
- c. Even in the presence of a presumably correct diagnosis, the patient is not responding as anticipated.
- d. Under certain circumstances, consultation to specific specialties is strongly advised as described in the [“Plan for Provision of Care: Consultation Services – Indications for Consult.”](#)

9.7 Discharge Planning

- 9.7-1 Discharge planning shall be initiated as early as appropriate, usually the day of admission. Discharge planning applies not only to inpatient medical, neurological, psychiatric, and surgical beds, but also to Ambulatory Surgery, 23-hour observation stays, ICU/DOU, ADTP, Extended Care, and Spinal Cord Injury/Disease.
- 9.7-2 It will include provisions for continuity of care and referral to appropriate service(s) to meet patient needs.
- 9.7-3 The patient, or caregiver, or both, will be properly educated to carry out the discharge plan of care in the home/community environment. If a patient is referred to a skilled nursing facility or other community residential care, information necessary to accomplish the discharge plan will be provided.
- 9.7-4 All discharge planning will be documented thoroughly in the patient’s medical record.

9.8 Discharge

- 9.8-1 Patients who are being discharged from inpatient status should meet specific criteria as determined by the bed service chief or unit chief and recorded in a service or unit policy. (Exceptions that delay a discharge shall be approved by the attending physician or the appropriate service or unit chief and documented in a progress note.)
- 9.8-2 The information contained within the physician’s orders will include, but not be limited to: the date and type (if not regular) of discharge, follow-up clinic appointments, discharge medications, diet prescription, return to work or pre-hospital activity prescription, special travel requirements, and the date of dictation or completion of the hospital discharge summary.
- 9.8-3 Whenever possible, physicians are to enter discharge orders and prescriptions by 3 p.m. the day prior to the discharge, except for Sundays and holidays falling on Mondays when the order should be entered by 12:30 p.m. the preceding Friday.
- 9.8-4 Discharge from the Post Anesthesia Care Unit (PACU) will be based on an order from a physician who is familiar with the patient or, when the physician is not immediately available, on relevant Medical Staff approved criteria. The discharge physician’s name shall be recorded in the patient’s medical record.
- 9.8-5 The Ambulatory Surgical Unit (ASU) is utilized for selected patients requiring care in an Operating Room, Interventional Radiology, Cardiac Cath Lab, or PACU, or other areas where anesthesia or moderate sedation is performed, and there is not a

need for pre-procedure hospitalization. Following the procedure, an ASU patient receiving general anesthesia or regional block anesthesia will be recovered immediately in the PACU. Any patient requiring prolonged observation or failing to meet discharge criteria from ASU will be evaluated for admission to a 23-hour observation stay bed or to an inpatient bed service.

- 9.8-6 The 3 South Procedure Center is utilized for selected patients requiring certain interventional procedures (e.g. bronchoscopy, GI endoscopy, pain relief procedures, and dermatologic procedures) that may require sedation. Any patient requiring prolonged observation or failing to meet discharge criteria from the Procedure Center will be evaluated for admission to a 23-hour observation stay bed or to an inpatient bed service.

References:

[VASDHS MCM 11E-01 Supervision Of Postgraduate Medical And Dental Residents](#)
[VASDHS MCM 04-27, Admissions](#)
http://vawww.docushare.visn22.med.va.gov/dscgi/ds.py/Get/File-2154/MCM_118-05.doc
[MCM 11-14 Interdisciplinary Care and Discharge Planning](#)
[MCM 112-08 Ambulatory Surgery](#)
[MCM 11-31 Sedation](#)
[VHA Handbook 1106.1 - Pathology & Laboratory Medicine Service Procedures](#)
[VHA Manual M-2, Part VI, Chapter 8](#)
[MCM 113-15 Autopsy Services](#)
[MCM 11-42 Medical Center Patient Assessment Policy](#)
[MCM 05-11 Employee Rights Related to Patient Care](#)

RULE 10

PHYSICIAN'S ORDERS

10.1 General Requirements

- 10.1-1 All orders for treatment shall be entered into CPRS, dated and signed. When orders are entered in the computer, password-controlled electronic signatures will be required.
- 10.1-2 All orders for treatment will be administered only on the properly executed order of a member of the Medical Staff, or an authorized member of the medical or dental housestaff, or other practitioner granted the scope of practice to enter such orders.
- 10.1-3 Medication orders entered by medical students or clinical clerk “sub-interns” will not be accepted.
- 10.1-4 Verbal and telephone orders:
 - a. Verbal orders (in an emergency) and telephone orders (when urgent and CPRS is not available) of authorized providers may be accepted by an RN, Pharmacist, or other practitioner granted the scope of practice to accept such an order. Such orders should be limited to emergent situations or unavoidable absence of the authorized provider, as noted above. The order, either verbal or telephonic, will be entered into the medical record and indicate the author.
 - b. In order to assure accurate transcription of verbal or telephone orders, the individual accepting such orders will utilize a process of “read-back” verification of the complete order to the authorized provider and require a confirmation of the read-back order before releasing or implementing the order. Verbal orders for the administration of pharmaceuticals require that the prescriber sign a verbal or telephone order within 48 hours.
- 10.1-5 Investigational drugs shall be dispensed and administered as authorized under [MCM 151-02, Drugs under Clinical Study in Humans](#).
- 10.1-6 Self-administration of medication by inpatients shall be permitted only under conditions prescribed in [MCM 119-14 “In-Patient Self-Medication Program”](#) or, by exception, authorized by the Chief of Service and the Chief, Pharmacy Service, or his/her designee. This authorization must be obtained prior to initiation of medication self-administration.
- 10.1-7 During the event of computer downtime or failure, written orders will be used. The physician’s signature shall be accompanied by the physician identifier number, dated, and timed. Printed facsimiles may accompany, but not replace, signatures.

10.2 Automatic Stop Orders

All drug and treatment orders are automatically discontinued at 1 p.m. on the last day of the period indicated in the [MCM 11-08 “Medication Orders for Inpatients”](#), unless a specific number of doses is ordered. The period of prescription begins the day the order is written.

10.3 Submission of Surgical Specimens

All tissues or foreign bodies removed at the time of surgery or other invasive procedure, including biopsies, shall be sent to Pathology and Laboratory Medicine Service where such examination as is deemed necessary to arrive at a diagnosis shall be performed. Certain specimens may be excluded, as approved by the MEC, on recommendation of the Procedures and Anesthesia Care Council of the Medical Staff.

10.4 Special Treatment Procedures

10.4-1 The following special treatment procedures require special documentation in the medical record by a staff physician and/or specific informed consent as necessary.

- a. DNAR (Do Not Attempt to Resuscitate), Advance Directive (AD), and Withholding/Withdrawal of Life Sustaining Treatment.
- b. Any licensed physician can institute a DNAR order with attending physician concurrence; however, such orders must follow the policies and procedures as outlined in [Medical Center Memorandum 11-05 “Do Not Attempt to Resuscitate \(DNAR\) Orders and Withdrawal of Life Sustaining Therapy.”](#)
- c. Any member of the Medical Staff, for whatever reason, may choose not to be involved in writing DNAR orders. Medical Staff membership is not dependent upon, nor does it require participation in, DNAR decisions.

10.4-2 Protective Security, Restraint, and Seclusion

- a. Placing a patient in restraint and/or seclusion will be guided by [MCM 00-18 “Patient and Nursing Home Resident Rights and Responsibilities”](#) and [MCM 11-20 “Policy on Restraints.”](#)
- b. If a patient must be restrained and/or secluded, a physician’s order must be obtained within one hour of beginning seclusion or restraint. A patient who is released from restraint for a trial period may be restrained again, without a new written order, provided restraint is for the same condition as previously restrained.
- c. Requirements regarding maximum time an intervention may be used, periodic patient observation and documentation, both of observation and that the needs of the patient are attended to, are delineated in [MCM 11-20 “Policy on Restraints.”](#)

10.4-3 Legal Hold Status

No patient in a legal hold status under the Lanterman Petris Short (LPS) Act (California Mental Health Services Act, January 1981) will be discharged, released, or removed from this status except as prescribed in the Policies and Procedures of the Psychiatry Service as approved by the MEC.

10.4-4 Electroconvulsive Therapy (ECT)

ECT may be performed by, or under the supervision of, a privileged provider with patient or surrogate informed consent for treatment of appropriate diagnoses, under the provisions and protection of Psychiatry Service, Statement of Policy 21, Electroconvulsive Therapy, MCM 11-43, Informed Consent, and the Policies and Procedures of the Psychiatry Service as approved by the MEC.

References:

VHA Manual M-2, Part X: General Administration, Mental Health Service
VHA Manual M-2, Part I, Chapter 30, Clinical Affairs
MCM 00-18, Patient and Nursing Home Resident Rights and Responsibilities
[MCM 11-05 Do Not Attempt to Resuscitate \(DNAR\) Orders and Withdrawal of Life Sustaining Therapy:](#)
[MCM 11-08, Medication Orders for Inpatients](#)
[MCM 11-20 Policy on Restraints](#)
[MCM 11-37 Advanced Directive for Health Care](#)
[MCM 11-43, Informed Consent](#)
[MCM 119-14 In-Patient Self Medication Program](#)
[MCM 151-02 Drugs under Clinical Study in Humans](#)
Psychiatry Service, Statement of Policy 21, Electroconvulsive Therapy

RULE 11

ROLE OF ATTENDING

11.1 Supervision of Residents and Non-Physicians

All housestaff will be supervised by members of the Medical Staff. Details related to procedural requirements of supervision and documentation of supervision can be found in [VHA Handbook 1400.1 - Resident Supervision](#) including any updates or supplements thereto and [MCM 11E-01-Supervision of Postgraduate Medical and Dental Residents](#).

- 11.1-1 -.Housestaff may write patient care orders and otherwise provide care for patients in accordance with MEC approved policies, specific to each service, which delineate such responsibility.
- 11.1-2 A member of the Medical Staff will supervise all patient care activities performed by non-physicians (e.g., PAs, CRNAs, and NPs, as well as medical students) unless otherwise specified in an approved Scope/Standard of Practice.

References:

[VHA Handbook 1400.1, Resident Supervision](#)
[VHA Handbook 1100.19, Credentialing and Privileging](#)
[MCM 11-43, Informed Consent](#)
[MCM 136-32 Control and Monitoring of of Medical Records](#)
[MCM 11-62, Electronic Patient Care Orders](#)
[MCM 11E-01-Supervision of Postgraduate Medical and Dental Residents](#)

RULE 12

MEDICAL RECORDS

12.1 Basic Documentation Requirements

- 12.1-1 Entries to, and completion of, the medical record will be accomplished in a timely manner, and will be dated and signed. Details related to the procedural, content, and completion requirements of medical records can be found in [MCM 136-10 - Medical Record Requirements](#).
- 12.1-2 CUTTING AND PASTING BETWEEN NOTES IS STRONGLY DISCOURAGED. IN ANY INSTANCE WHERE TEXT IS COPIED FROM A PRIOR NOTE AND NOT MODIFIED OR UPDATED, THE ORIGIN OF THE TEXT MUST BE SPECIFICALLY CITED. Do not copy entire laboratory findings, radiology reports, entire problem lists and other information verbatim into a note. Refer to this information without copying verbatim.
- 12.1-3 Documentation should not be a mirror image of previous notes. Appropriate use of templates can reduce time spent documenting while providing pertinent information. If templates are used, the wording should be changed to reflect the care provided for the episode of care.
- 12.1-4 It is acceptable to refer to current documentation in CPRS that was reviewed rather than repeating for inserting the information into the note.
- 12.1-5 Changes to the basic administrative requirements are the responsibility of the Medical Records Committee both for format and content of the medical record. The Medical Staff will approve substantive changes, including decisions regarding format, such as the way in which the electronic or paper record is maintained. Additional details related to administrative requirements can be found in [MCM 11-12, Medical Records Committee](#) and [MCM 11-22, Electronic Entry Of Medical Record Information](#).

12.2 Basic Clinical Information Requirements

- 12.2-1 Medical record documentation will be complete and clinically pertinent. Clear and accurate manual and/or electronic entries will address identifying information, historical information, relevant physical examination findings, the diagnosis(es) or impression(s), pertinent results of diagnostic tests (normal or abnormal), therapy rendered, and clinical observations, including responses to treatment, risk factors that have bearing on treatment, patient condition, and progress. The inpatient record will also document condition at discharge, discharge disposition, medications, activity, and diet instructions.
- 12.2-2 The medical record will also contain a summary of the patient's psychosocial needs, functional status assessment, diagnostic and therapeutic orders, evidence of informed consent, where appropriate, and clinical observations, which shall include, but not be limited to, the results of therapy, pertinent reports of procedures and tests (normal and abnormal), and consultations.

- 12.2-3 The attending physician is responsible for insuring that the medical record is complete and legible for each patient under his/her care.

12.3 Inpatient Medical Records

- 12.3-2 The inpatient record will include, but not be limited to, the following:

- d. A pertinent admission assessment will be completed within 24 hours of admission. This will include the chief complaint, details of the present illness, a review of systems, relevant past social, family and medical/surgical/psychiatric history, functional status, a description of the conclusions, diagnosis(es), or impressions drawn from the admission history and physical examinations, as well as appropriate pertinent laboratory and radiologic procedures (normal and abnormal).
- e. The admission assessment will reflect a comprehensive current assessment. It will be dated and signed by a physician. Physical examinations by medical students, interns, and other non-licensed physicians, nurse practitioners, or physician assistants, will be confirmed and co-signed by an attending physician. The comprehensive assessment will be periodically reviewed and updated thereafter, as appropriate. When an admission or pre-procedure assessment has been completed in the outpatient area prior to admission on the procedure, a note, referring to the assessment and updating relevant findings, will be entered. For patients readmitted within 30 days, the provider may refer to the prior admission assessment and update relevant information pertaining to the recent period.
- f. Except in extreme emergencies, surgery or other procedures will be performed only after a history and physical examination, and any indicated laboratory and X-ray examinations have been completed, the pre-procedure diagnosis(es) has/have been recorded in the medical record, and the attending physician has concurred in writing with the assessment and plan for care.
- g. Pertinent progress notes shall be recorded regularly. A progress note by a physician will be written at least daily for a critically ill patient or for any patient where achieving a diagnosis or managing clinical problems is difficult. Entries in the progress notes may be made by physicians, nursing staff, and/or other authorized individuals. Where appropriate, each of the patient's current clinical problems will be clearly identified and correlated with specific plans/orders, as well as results of tests and treatment.
- h. Consultations, when sought, will consist of the consultant's considered opinion and recommendations and reflect an examination of the patient and the patient's medical record appropriate to the consultation. Consultants who undertake specific diagnostic or therapeutic procedures for hospitalized patients will do so only with the knowledge and concurrence of the attending physician responsible for the patient during his/her hospitalization.
- i. A discharge summary will be entered prior to discharge for every patient. It should contain sufficient information to justify the admission, the diagnosis(es), concisely recapitulate the hospitalization, including the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as

appropriate. Instructions regarding physical activity after discharge, medications, diet, and follow-up care will also be included.

- j. Final diagnoses (all relevant diagnoses established by the time the patient is discharged as well as those pre-existing or transient during hospitalization for which the patient received care while hospitalized) and all operative or other procedures performed will be recorded using acceptable terminology. A responsible practitioner should record these at the time of discharge of every patient.

12.3-2 Discharge Summary:

- a. The discharge summary needs to be prepared for all releases from VHA care, including deaths. Transfers to other levels of care, such as: VHA domiciliary care, VHA nursing home, or other VHA medical centers, must be documented by a discharge summary.
- b. Responsibility for the preparation of the discharge summary and for its content rests exclusively with the member of the medical staff having primary care responsibility for the patient. The treating specialty from which the patient is discharged is responsible for completing the summary.
- c. The summary should be documented prior to discharge, or within 24 hours of death or irregular discharge. When the discharge summary is completed more than 24 hours prior to discharge, local policy determines the timeframe when an addendum is required.
- d. If not the author, the supervising practitioner must review the summary, make appropriate edits, and indicate approval by co-signature.
- e. Summaries must be prepared as follows:
 - 1) **Diagnosis.** List the principal diagnosis, i.e., that condition established after study to be chiefly responsible for the admission of the patient to the hospital for care; then, in order of clinical importance, list all other diagnoses for which treatment was given. Diagnoses must include post-operative complications or infections and drug or serum reactions. All diagnoses need to include a site and etiology, when applicable, and must be stated in full, without symbols and/or abbreviations, and in accordance with the latest edition of International Classification of Disease (ICD).
 - 2) **Psychiatric Diagnoses.** Diagnoses must be stated in accordance with the latest edition of Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis must be recorded in AXIS format and, if applicable, must include the Global Assessment of Functioning (GAF) score.
- f. Operations and surgical procedures must be stated in full, without symbols and/or abbreviations, and in accordance with the latest edition of CPT and/or ICD Procedural Index. The site involved and the procedures performed must be stated. The listing must include all operations, diagnostic and therapeutic procedures, and the date performed. All procedures need to be documented in the text of the summary.
- g. The body of the Discharge Summary must include:
 - 1) The name of the member of the medical staff responsible for patient's care and the primary physician, if applicable.

- 2) The reason for admission (principal diagnosis, i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital).
 - 3) Other diagnoses and/or conditions treated.
 - 4) All operations and procedures performed and the treatment rendered during current admission, with dates.
 - 5) Pertinent past medical history.
 - 6) Pertinent points in review of systems (including allergies or drug sensitivities).
 - 7) Pertinent findings of laboratory and radiological data.
 - 8) Pertinent findings of the physical examination, particularly abnormalities.
 - 9) Brief course in hospital stay to include treatment received and condition on discharge. **NOTE:** *Condition must be more specific than “improved” and needs to permit measurable comparison with condition on admission.*
 - 10) Condition of wound, if applicable.
 - 11) Place of disposition, i.e., home, nursing home, etc.
 - 12) Discharge instructions to patient, or responsible other, to include:
 - i) Information regarding condition or proper home care.
 - ii) Medical follow-up. **NOTE:** If a private physician, state the name if possible.
 - iii) Medications on discharge.
 - iv) Diet instructions.
 - v) Activity and/or limitations.
 - vi) Specific date to return to work. **NOTE:** State if a period of convalescence is required, if retired, or if any of this is to be determined at a later date.
 - 13) If the patient has a psychosis or an organic mental impairment, there must also be a statement regarding the patient’s competency to handle VA funds.
 - 14) If summary concerns a death case, there must be a statement that an autopsy was or was not performed.
- h. Autopsy
- 1) Preliminary or provisional anatomical diagnoses must be documented within 72 hours of autopsy.
 - 2) Final protocols must be completed, signed, and properly filed within 30 days of autopsy.
 - 3) The Death Certificate must be amended when the results of an autopsy require a change in cause of death.

12.4 Operative and Other Invasive Procedures

- 12.4-1 A pre-procedure assessment appropriate to the planned procedure shall be completed prior to the procedures and documented in the medical record.
- For operative procedures, the Physicians Admission H&P will be used.
 - For other procedures, an alternate note title may be used.
 - In both cases, if the above is provided by a resident, the supervisory practitioner must evaluate the patient and write a pre-procedural note describing the finding, diagnosis, plan for treatment and/or choice of specific procedure to be done. This note may be done up to 30 days in advance, but must be updated. (This does not apply to simple procedures such as LPs, centeses, skin biopsies, etc.)
- 12.4-2 When an initial history, physical examination, and assessment are not recorded before an operative procedure, the procedure will be canceled unless the attending physician states in writing that such a delay would be detrimental to the patient. Such a note must appear in the patient's medical record in the Progress Notes section and a history, physical examination, and assessment completed promptly thereafter, but no later than 24 hours following the procedure.
- 12.4-3 Each operative or other procedure will be immediately documented by a brief progress note containing sufficient information to permit other caregivers to provide appropriate ongoing care. This note will contain the pre-operative or pre-procedure diagnosis, a brief description of findings, the type of anesthesia used, the technical procedure(s) used, a description of specimens removed, estimated blood loss, the post-operative or post-procedure diagnosis, the level of housestaff supervision, and the name of the attending supervising the procedure, as well as any assistants present. Progress note entries and operative or procedure reports are required for both in-patient and outpatient procedures.
- 12.4-4 A final operative or procedure report will be entered in or dictated for the medical record and will document the details of the operation or procedure, including all information required in paragraph C. above. This will be done as soon as possible, but not more than 24 hours following the procedure.
- 12.4-5 Operations and surgical procedures must be stated in full, without symbols and/or abbreviations, and in accordance with the latest edition of CPT and/or ICD Procedural Index. The site involved and the procedures performed must be stated. The listing must include all operations, diagnostic and therapeutic procedures, and the date performed. All procedures need to be documented in the text of the summary. The attending physician will sign the operation report.

12.5 Outpatient Records

- 12.10-2 Ambulatory Care records will include, but not be limited to:
- Patient identification.
 - Relevant history of each illness or injury and or physical findings.
 - Allergies (drugs, foods, and other).
 - Clinical observations, including the results of treatment.
 - Treatment provided.

- f. Diagnosis(es) and/or impressions.
- g. Diagnostic and therapeutic orders.
- h. Patient disposition and any instructions given to the patient for care.
- i. Referrals to other practitioners or providers in or out of the VASDHS.
- j. Updates of information listed above, at the time of each visit.
- k. A separate cumulative “Problem List” of known significant diagnoses, conditions, procedures, and significant allergies, their dates of onset and/or resolution.
- l. A cumulative medication list containing prescribed medications, over the counter medications used by the patient, and drugs prescribed elsewhere will be documented in the medical record. This list is to be updated as necessary.
- m. A copy of the patient’s Advance Directive or living will, if one exists.

12.6 Observation Patient Record Documentation Requirements

A 23-hour observation patient is one who presents with a medical condition showing a significant degree of instability or disability, and who needs to be monitored, evaluated, and assessed for either admission to inpatient status or assignment to care in another setting. The length-of-stay in an observation bed is not to exceed 24 hours. Observation patient record documentation will include, but not be limited to:

- a. Admission order
- b. Initial assessment; History and Physical
- c. Progress notes
- d. Discharge order
- e. Discharge diagnosis
- f. Discharge Summary

12.7 Authentication

All entries in the medical record will be dated and authenticated. The authentication is to include the author’s signature and title (e.g., M.D., D.O., R.N., N.P., P.A., trainee status, etc.). When using CPRS, the user’s electronic signature block should also contain the appropriate title. Each clinical event is to be documented as soon as possible in relation to its occurrence. Only individuals given that right as specified in VA Directives and/or Medical Center Memoranda will make entries in the medical record. If a medical student makes an entry, the entry will be reviewed and authenticated by a licensed physician.

12.8 Consent for Release of Medical Information

Written consent of the patient or the patient’s legally qualified representative is required for the release of medical information to persons not otherwise authorized to receive the information. VASDHS is subject to federal confidentiality statutes and HIPAA/Privacy laws regarding the release of medical information. When there is doubt with respect to release of medical information contained in the medical record, Health Information Management Service (HIMS) should be consulted to assist in obtaining consent for release of information or interpreting the Privacy Act, Title 38 USC and relevant VHA directives.

12.9 Unauthorized Removal of Medical Records

No written medical record or electronic equivalent is to be removed from the hospital's jurisdiction except in accordance with a court order, subpoena or statute, which is congruent with Federal Law and VHA regulations. All records are the property of VHA and shall not otherwise be removed without permission of the Director. Unauthorized removal of, or electronic access to, any patient's medical record is grounds for suspension of clinical privileges or employment of the practitioner for a period to be determined by the Director. VHA disciplinary action may also be invoked.

12.10 Rules and Regulations Governing Medical Record Content

- 12.10-1 Medical records will conform to the Department of Veterans Affairs regulations, the Rules and Regulations of the Medical Staff and policies that are not in conflict with the above, which are approved by the MEC or the Medical Staff. The inpatient medical record, including the discharge summary, is to be completed within thirty (30) days following discharge. Service Chiefs and the Medical Records Committee will be notified of practitioners' delinquent in completion of medical records; the practitioner may be subject to suspension of clinical privileges or employment. Such action will be determined by the MEC and implemented by the COS/MD or the Chief of Service.
- 12.10-2 Delinquent Medical Records: The Chief, Health Information Management Service (HIMS) will provide Clinical Service Chiefs with a list of delinquent medical records on a weekly , but no longer than monthly basis. At the time of separation from SDVAHS, each physician must clear through HIMS. Clearance will occur only if all delinquent medical records are resolved.

References:

[MCM 11-22. Electronic Entry of Medical Record Information](#)

[MCM 11-43. Informed Consent](#)

[MCM 136-32 Control and Monitoring of of Medical Records](#)

[MCM 136-06. Privacy and Disclosure of Individually-Identifiable Health Information from Medical Records](#)

[VHA Handbook 1907.01 Health Information Management and Health Records](#)

RULE 13

PRACTITIONER WELL-BEING

13.1 Overview

- 13.1-1 Under appropriate circumstances, the COS/MD may appoint a Practitioner Well Being Committee for the purpose of supervising a rehabilitation process/ program for a member of the Medical Staff, a Licensed Independent Practitioner (LIP) or other Allied Health Professional (AHP) who is referred by a supervisor for, or voluntarily requests, intervention. The Practitioner Well Being Committee of the UCSD SO Hospital or VASDHS may be asked by the appropriate Professional Standards Board (PSB) to serve as the monitoring body for a physician, LIP, or AHP. Appropriate staff from VASDHS will serve on any such committee when such monitoring is requested.
- 13.1-2 The Practitioner Well Being Committee may be a Sub-Committee of the appropriate PSB established in [MCM 11-01 “Professional Standards Board.”](#) Under such circumstances, it will be comprised of no less than three (3) members of the Medical Staff, LIP or AHP, as appropriate. A technical advisor from HRMS shall assist the Committee. Members of this Committee, as it is from time to time constituted, should not serve concurrently as active participants on other peer review committees, nor should they have any conflict of interest in serving on this committee. The Practitioner Well Being Committee shall receive reports related to the health, well being, or impairment of staff members and may investigate such reports. The Committee may, on a voluntary basis, provide advice, counseling, or referrals as appropriate. Such activity shall be confidential. In the event the information received by the Committee clearly demonstrates that the health or known impairment of the staff member poses a risk to patients, the information may be referred for corrective action in accordance with VHA policies and regulations. The Practitioner Well Being Subcommittee of a PSB will meet as often as necessary. It will maintain such records of its proceedings as it deems advisable and shall report directly to the COS/MD as Chairman of the MEC and as President of the Medical Staff or to the ACOS Nursing, as appropriate.
- 13.1-3 If the Well Being Committee formally decides that the staff member should be referred for evaluation and/or treatment, this shall be done as recommended by the California State Licensing Board. Generally, this will involve the development of a monitoring program to allow for restoration of clinical privileges.
- 13.1-4 The PSB, as a body, will determine the extent of restriction of any clinical privileges upon report of the Practitioner Well Being Subcommittee. A member’s return to his/her previous clinical privileging status and the specifics of his/her monitoring program shall be governed by a contract with the member of the staff affected. The contract shall allow for reports from outside self-help groups such as 12-Step, Medical Society Aid Program, Diversion Program, and other such therapeutic groups and organizations. Participation by the staff member affected can be mandatory under the contract. The contract will allow for summary loss of privileges should the staff member, under the contract, fail to maintain performance or behavior standards as set forth therein. Due process rights may be limited to factual issues, not to the right of the PSB or the DVA to take action.

RULE 14

INFECTION CONTROL

14.1 Overview

- 14.1-1 The hospital uses precautions designed by the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control (CDC) to prevent transmission of infectious agents when dealing with patients, blood, body fluids, or items contaminated by body fluids, and tissue specimens. All personnel, including Medical Staff, are required to wear appropriate personal protective equipment. The hospital is required to provide such medical equipment. Details of the infection control program can be found in [MCM 11-09, Infection Control Program](#).
- 14.1-2 The Infection Control Manual contains policies and procedures pertinent to infection control. These policies are to be followed by all members of the Medical Staff and other practitioners within the hospital. Policies referenced below govern hospital-wide practice. Specific unit or service level infection control policies are contained in Section IV of the Manual.
- 14.1-3 The possibility of exposure of persons to a communicable disease, either in the community or in the hospital, can result in the spread of infection to patients and other staff. Medical staff will be included in immunization programs, offered therapy, and provided follow-up evaluation when inadvertent exposure occurs. It is each practitioner's responsibility to report communicable diseases when they are diagnosed to the County Department of Health Services as required by law and outlined in [MCM 113-21, Reportable Medical Conditions](#).

References:

[MCM 11-09, Infection Control Program](#)
[MCM 11-36, Tuberculosis Plan](#)
[MCM 111-06, Intravascular and Pressure Monitoring Therapy](#)
[MCM 111-12, Communicable Disease Exposure](#)
[MCM 113-21, Reportable Medical Conditions](#)
[Infection Control and Surveillance Website](#)
[VHA Manual M-2, Part IV, Chapter 8, Infectious Diseases](#)

RULE 15

DISASTER PLAN

15.1 Overview

- 15.1-1 To ensure the safety of all medical staff and patients and to provide maximum support to the community while maintaining essential patient care activities during emergencies, the hospital has established a [Master Emergency Plan](#). This plan will be rehearsed at least twice a year, and reviewed and updated at least once every two years by the Emergency Planning Committee.
- 15.1-2 The hospital, as mandated by Public Law 94-174, will actively support the Department of Defense (DOD) during, and immediately following, any national emergency as declared by the President or Congress. The hospital is notified by the Navy Medical Center, the VISN 22 Director, or the Chief Network Officer of the VHA that such a disaster has occurred and that the plan is to be implemented.
- 15.1-3 In the event of a disaster in which the facility [Master Emergency Plan](#) has been activated, the Chief of Staff or designee, with authorization from the Director, may grant disaster privileges. The Medical Staff Office will be responsible for verifying, as a top priority, pertinent information for disaster privileges. The process of granting disaster privileges is found in Article 5.5 of the Bylaws Disaster and Emergency Privileges.

References:

Public Law 94-174

[MCM 11-38 Credentialing Physicians, Advanced Level Practitioners in the Event of a Disaster:](#)