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

SAN FRANCISCO VETERANS AFFAIRS HEALTH CARE SYSTEM
SAN FRANCISCO, CALIFORNIA
# Table of Contents

PREAMBLE 1  
ACRONYMS 1  
DEFINITIONS 3  

ARTICLE I. NAME 9  

ARTICLE II. VISION, MISSION, VALUES, AND PURPOSE 9  
Section 2.01 Vision 9  
Section 2.02 Mission 8  
Section 2.03 Values 9  

ARTICLE III. MEDICAL STAFF MEMBERSHIP 11  
Section 3.01 Eligibility for Membership on the Medical Staff 11  
Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges 12  
Section 3.03 Code of Conduct 14  
Section 3.04 Basic Responsibilities of Medical Staff Membership 15  
Section 3.05 Medical Staff Leadership in Performance Improvement Activities 16  

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF 16  
Section 4.01 Leaders 16  
Section 4.02 Leadership and Officers 18  
Section 4.03 Clinical Services 18  

ARTICLE V. MEDICAL STAFF COMMITTEES 22  
Section 5.01 General 22  
Section 5.02 Executive Committee of the Medical Staff 22  
Section 5.03 Committees of the Medical Staff 25  
Section 5.04 Committee Records and Minutes 25  
Section 5.05 Establishment of Committees 26  

ARTICLE VI. MEDICAL STAFF MEETINGS 26  

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING 26  
Section 7.01 General Provisions 26  
Section 7.02 Application Procedures 30  
Section 7.03 Process and Terms of Appointment 34  
Section 7.04 Credentials Evaluation and Maintenance 35  
Section 7.05 Local/VISN-Level Compensation Panels 37  

ARTICLE VIII. CLINICAL PRIVILEGES 37  
Section 8.01 General Provisions 37  
Section 8.02 Process and Requirements for Requesting Clinical Privileges 39  
Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges 41
Section 8.04 Processing an Increase or Modification of Privileges 43
Section 8.05 Recommendations and Approval for Initial/Renewal, Modification/Revision of Clinical Privileges 43
Section 8.06 Exceptions 44
ARTICLE IX. ALLIED HEALTH PRACTITIONERS 47
Section 9.01 Qualifications 47
Section 9.02 Credentialing Allied Health Professionals 48
Section 9.03 Dependent Credentialing of Health Care Practitioners 48
ARTICLE X. INVESTIGATION, SUMMARY SUSPENSION, AND ACTION 48
ARTICLE XI. FAIR HEARING AND APPELLATE REVIEW 56
ARTICLE XII. RULES AND REGULATIONS 61
ARTICLE XIII. AMENDMENTS 61
ARTICLE XIV. ADOPTION 62
MEDICAL STAFF RULES 63
1. GENERAL 63
2. PATIENT RIGHTS 63
3. RESPONSIBILITY FOR CARE 68
4. INVESTIGATIONAL DRUGS 72
5. PHYSICIANS’ ORDERS 73
6. INCIDENT REPORTING 76
7. ROLE OF ATTENDING STAFF 76
8. MEDICAL RECORDS 78
9. INFECTION CONTROL 84
10. CONTINUING EDUCATION 85
11. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM 85
12. DISASTER 86
13. PEER REVIEW 86
Appendix A – Fair Hearing and Appellate Review 88
PREAMBLE
Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the Veteran Affairs (VA) Health Care System in San Francisco, California (hereinafter sometimes referred to as SFVAHCS) hereby organizes itself for self-governance in conformity with the laws, regulations, and policies governing the Department of Veterans Affairs, Veterans Health Administration (VHA), and the Bylaws and Rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing the VHA, and they do not create any rights or liabilities not otherwise provided for in laws or VHA Regulations.

The San Francisco VA Health Care System comprises the Medical Center, Community Living Center (CLC), and Community Based Outpatient Clinics (CBOCs) located in Clearlake, Eureka, San Bruno, downtown San Francisco, Santa Rosa, and Ukiah.

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

ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
</tr>
<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
</tr>
<tr>
<td>ACOS</td>
<td>Associate Chief of Staff</td>
</tr>
<tr>
<td>AD</td>
<td>Associate Director</td>
</tr>
<tr>
<td>AD-PCS</td>
<td>Associate Director of Patient Care Services</td>
</tr>
<tr>
<td>AHP</td>
<td>Allied Health Practitioner</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychological Association</td>
</tr>
<tr>
<td>APRN</td>
<td>Advanced Practice Registered Nurses</td>
</tr>
<tr>
<td>BCLS</td>
<td>Basic Cardiac Life Support</td>
</tr>
<tr>
<td>C&amp;P</td>
<td>Credentialing and Privileging</td>
</tr>
<tr>
<td>CBOC</td>
<td>Community Based Outpatient Clinic</td>
</tr>
<tr>
<td>CDA</td>
<td>California Dental Association</td>
</tr>
<tr>
<td>CDS</td>
<td>Controlled Substance Number</td>
</tr>
<tr>
<td>CFR</td>
<td>Code of Federal Regulation</td>
</tr>
<tr>
<td>CLC</td>
<td>Community Living Center</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>CMO</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>COS</td>
<td>Chief of Staff</td>
</tr>
<tr>
<td>CPRS</td>
<td>Computerized Patient Record System</td>
</tr>
<tr>
<td>Acronym</td>
<td>Term</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>CRNA</td>
<td>Certified Registered Nurse Anesthetist</td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Agency</td>
</tr>
<tr>
<td>DMAT</td>
<td>Disaster Medical Assistance Team</td>
</tr>
<tr>
<td>DNR</td>
<td>Do Not Resuscitate</td>
</tr>
<tr>
<td>DOB</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>DoD</td>
<td>Department of Defense</td>
</tr>
<tr>
<td>ECFMG</td>
<td>Educational Commission for Foreign Medical Graduates</td>
</tr>
<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment Act</td>
</tr>
<tr>
<td>ERB</td>
<td>Executive Resource Board</td>
</tr>
<tr>
<td>FPPE</td>
<td>Focused Professional Practice Evaluation</td>
</tr>
<tr>
<td>FSMB</td>
<td>Federation of State Medical Boards</td>
</tr>
<tr>
<td>H&amp;P</td>
<td>History and Physical</td>
</tr>
<tr>
<td>HICS</td>
<td>Hospital Incident Command System</td>
</tr>
<tr>
<td>HIMS</td>
<td>Health Information Management System</td>
</tr>
<tr>
<td>HIPDB</td>
<td>Health Integrity and Protection Data Bank</td>
</tr>
<tr>
<td>HIPPA</td>
<td>Health Insurance Portability &amp; Accountability Act</td>
</tr>
<tr>
<td>HRMS</td>
<td>Human Resources Management Service</td>
</tr>
<tr>
<td>HRRP</td>
<td>Human Research Protection Program</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>LIP</td>
<td>Licensed Independent Practitioner or Provider</td>
</tr>
<tr>
<td>LVN</td>
<td>Licensed Vocational Nurse</td>
</tr>
<tr>
<td>MCM</td>
<td>Medical Center Memorandum</td>
</tr>
<tr>
<td>MEC</td>
<td>Medical Executive Committee</td>
</tr>
<tr>
<td>MSO</td>
<td>Medical Staff Office</td>
</tr>
<tr>
<td>No.</td>
<td>Number</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>NPDB</td>
<td>National Practitioner Data Bank</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>OPPE</td>
<td>Ongoing Professional Practice Evaluation</td>
</tr>
<tr>
<td>P&amp;T</td>
<td>Pharmacy and Therapeutics</td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>PACU</td>
<td>Post Anesthesia Care Unit</td>
</tr>
<tr>
<td>PDS</td>
<td>Proactive Disclosure Service</td>
</tr>
<tr>
<td>PSB</td>
<td>Professional Standards Board</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>QM</td>
<td>Quality Management</td>
</tr>
<tr>
<td>RCS</td>
<td>Record Control System</td>
</tr>
<tr>
<td>RDH</td>
<td>Registered Dental Hygienist</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>ROI</td>
<td>Release of Information</td>
</tr>
<tr>
<td>SFVAHCS</td>
<td>San Francisco VA Health Care System</td>
</tr>
<tr>
<td>SOAP</td>
<td>Subjective/Objective/Assessment/Plan</td>
</tr>
</tbody>
</table>
DEFINITIONS

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

1. **Allied Health Practitioners**: The term includes those individuals who participate directly in the management of patients under the general supervision, direction of, or in collaboration with Medical Staff members. They shall be appointed to a specific service and shall carry out their activities subject to service policies and procedures. Allied Health Practitioners will include, but not necessarily be limited to Dietitians, Audiologists, Speech Pathologists, Physical Therapists, Pharmacists, Social Workers, Registered Dental Hygienists, and Occupational Therapists. They shall not be members of the Medical Staff.

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

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

4. **Automatic Suspension of Privileges**:

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

5. **Biennial Ongoing Professional Practice Evaluation (OPPE):** As used in this document, a biennial OPPE is a process in which the Service and/or Section Chief reviews the results of each Practitioner's Service OPPE, which is conducted every six months and professional performance at the time of privilege renewal. The Biennial OPPE form is reviewed by the Physicians’ Professional Standards Board (PSB) and maintained by the Chief of Staff’s Office, while the Service OPPEs are maintained in the Service. The OPPE is protected under The Federal Privacy Act of 1974 (5 United States Code (U.S.C.) 522) and under VHA Regulations 77VA10Q.

6. **Chief of Staff (COS):** The Chief of Staff is the President of the Medical Staff and Chairperson of the Medical Executive Committee and acts as full assistant to the Director in the efficient management of clinical and medical services to eligible patients and the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioners, Advanced Practice Professionals, and Allied Health Practitioners. The Chief of Staff ensures the ongoing medical education of Medical Staff.

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

8. **Contract Practitioners:** Contractor or subcontractor Practitioners are subject to compliance of this facility’s Bylaws and VA policies as well as being reported to the National Practitioner Data Bank or respective state licensing board for substandard care, professional misconduct, or professional incompetence. Removal of a contract practitioner from a contract results in an automatic revocation of privileges. The Contract Provider will be afforded a limited fair hearing to determine only if the revocation of privileges was based upon substandard care, professional misconduct, or professional incompetence and reportable to the National Practitioner Data Bank (if Practitioner is a physician or dentist).

9. **Credentialing:** Is the process to collect, access, and verify information regarding: current licensure, education, and relevant training as well as experience, ability, and current competence to perform the requested privilege(s).

10. **Dean’s Committee:** A Committee established by a formal memorandum of affiliation between the SFVAHCS and the University of California, San Francisco
(UCSF) and approved by the Under Secretary for Health, VHA. The Committee is composed of the Dean, School of Medicine, Chairs and senior faculty members of UCSF, representative(s) of the medical/dental staffs of SFVAHCS and representatives of other affiliated academic institutions as are appropriate to consider and advise on the development, management, and evaluation of all educational and research programs conducted at the facility.

11. **Director (Facility Director or Medical Center Director):** The Director (sometimes called Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Chief of Staff, the Deputy Director, the Associate Director for Patient Care Services, and the Medical Executive Committee.

12. **Facility:** The term refers to all patient care locations and clinical research locations designated within the SFVAHCS including CBOCs located in Clearlake, Eureka, San Bruno, downtown San Francisco, Santa Rosa, and Ukiah.

13. **Focused Professional Practice Evaluation (FPPE):** An evaluation process in which the Service Chief can evaluate a Practitioner’s performance. A FPPE will be utilized to confirm initial privilege competency by proctoring or as a focused review of ability to deliver safe, high-quality patient care when questions of competency have been raised. The FPPE is protected under The Federal Privacy Act of 1974 (5 USC 522) and under VHA Regulations 77VA10Q.

14. **Governing Body:** The term Governing Body refers to the Under Secretary for Health, the individual to whom the Secretary for VA has delegated authority for administration of the VHA; and it refers to the Facility Director for purposes of local facility management and planning. The Director is responsible for the oversight and delivery of health care by all employees and specifically including the Medical Staff credentialed and privileged by the relevant administrative offices and facility approved processes.

15. **House Staff:** Includes all individuals who are engaged in a graduate training program in medicine.

16. **Licensed Independent Practitioner:** The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the SFVAHCS to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted privileges. At SFVAHCS, LIPs include Physicians, independent privileged Psychologists, Optometrists, Podiatrists, Dentists, Nurse Practitioners (NPs), and Clinical Nurse Specialists (CNSs). It may also include individuals who can practice independently and meet the criteria for independent practice.

17. **Medical Staff:** The body of all Licensed Independent Practitioners credentialed through the Medical Staff process who are subject to the Medical Staff Bylaws. The Medical Staff shall consist of all full-time and part-time (includes Interagency Personnel Appointments and Contract) Physicians, NPs, CNSs, Dentists, Podiatrists, Optometrists, and independently privileged Psychologists under the authority of Title 38 U.S.C. Section 7401, 7405 - 7407, 7402 (a) - (d), Title 5 Code
of Federal Regulations 316.402(a), 315.501, 315.502, and other applicable statutes, who are professionally responsible for specific patient care and/or education and/or research activities of the SFVAHCS and who assume all the functions and responsibilities of membership on the staff. Members of the Medical Staff shall be appointed to a specific service, eligible to vote and serve on Medical Staff committees, and shall be required to attend Medical Staff meetings.

18. **Advanced Practice Professionals**: Advanced Practice Professionals are those health care professionals who are not physicians and dentists and who will function within a Scope of Practice and when applicable, a formulary, as defined in these Bylaws. Advanced Practice Professionals include: Physician Assistants (PAs), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Pharmacy Specialists. These Practitioners are not independent practitioners and are under direct supervision of a Licensed Independent Practitioner (LIP). Advanced Practice Professionals’ prescriptive authority to initiate prescriptions for formulary drugs or prescribe controlled substances, is by virtue of state licensure regulations, Federal Regulations, specific VHA Directives, scope of practice and corresponding formulary if applicable.

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

20. **Organized Medical Staff**: The body of LIPs who are collectively responsible for adopting and amending Medical Staff Bylaws (i.e., those with voting privileges) and for overseeing the quality of care, treatment, and services provided by all individuals with clinical privileges.

21. **Peer Recommendation**: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner’s clinical practice, ability to work as part of a team, and ethical behavior, or the documented peer evaluation of Practitioner-specific data collected from various sources. Peer Recommendations are for the purpose of evaluating current competence, developing recommendations for appointment to or termination from the Medical Staff, and for the initial and/or renewal granting of privileges or for revision or revocation of clinical privileges. Sources for peer recommendations may include reference letter(s), written documentation from identified sources, peers or supervisors. Peer recommendations and reviews in the context of credentialing, privileging, and adverse actions must remain distinct and different from USC Section 5705 protected peer review recommendations and activities.

22. **Practitioner/Provider**: This is defined as an appropriately licensed Physician, Dentist, Podiatrist, Optometrist, Psychologist, Nurse Practitioner, Clinical Nurse
Specialist or any Licensed Independent Practitioner, but does not include Advanced Practice Professionals and Allied Health Practitioners.

23. **Primary Source Verification:** Documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care Practitioner. This can be a letter, documented telephone contact, or secure electronic communication with the original source.

24. **Privileging:** The process whereby a specific scope and content of patient care services (clinical privileges) are authorized for a Licensed Independent Practitioner by SFVAHCS, based on evaluation of the individual's credentials and performance.

25. **Proctoring:** Proctoring is the activity by which a Practitioner is assigned to observe the practice of another Practitioner performing specified activities and to provide required reports on those observations. Proctoring at the SFVAHCS is structured to gain objective information about LIPs with newly approved clinical privileges including their clinical competence and medical decision-making skills with the intent of assuring the best care to the patients. A Focused Professional Practice Evaluation process will be utilized to confirm initial privilege competency. The Medical Staff Office will work with Service Chiefs and/or their designees who will assign proctors. The proctors will determine the proctoring complexity and timeframes. Proctoring must continue until the proctor is satisfied that an informed judgment can be made regarding the clinical competence of the Practitioner. Completed proctoring forms will be returned to the Medical Staff Office for submission to the PSB for review and recommended approval. All proctoring forms will be maintained in the Practitioner’s credential file. If the observing Practitioner is required to do more than just observe, i.e. exercise control or impart knowledge, skill, or attitude to another Practitioner to ensure appropriate, timely, and effective patient care, the action constitutes supervision. Such supervision may result in a reduction of privileges.

26. **Professional Standards Board:** The Professional Standards Board (PSB) is a session of the Medical Executive Committee and may act as a Credentials Committee on credentialing and clinical privileging matters of the Medical Staff, and when appropriate will make recommendations to the full MEC. This board also may act on matters involving Associated health and Advanced Practice Professionals such as granting prescriptive authority, scope of practice, and appointment. Some professional standards boards (e.g. Nursing, etc.) are responsible for advancement and other issues related to their respective professions.

27. **Provider Profile:** Service-specific file that contains data not derived from performance improvement activities for those LIPs who have ongoing professional practice evaluations at the SFVAHCS. Data are collected and evaluated on an ongoing basis to determine a LIP’s ability to perform requested privileges with an emphasis on quality of care and patient safety. The Provider Profile is protected under The Federal Privacy Act of 1974 5 USC 522 and under VHA Regulations 77VA10Q.

28. **Residents & Chief Residents:** The term ‘resident’ refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties such as Internal Medicine, Surgery, Psychiatry, Radiology, Nuclear Medicine, etc.),
Dentistry, Podiatry, Nurse Practitioner or Optometry and who participates in patient care under the direction of supervising Practitioners.

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

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

29. **Rules**: Refers to the specific rules set forth that govern the Medical Staff of the facility. The Medical Staff shall adopt such rules as may be necessary to implement more specifically the general principles found within these Bylaws. Rules are a separate document from the Bylaws. They can be reviewed and revised by the MEC and without adoption by the Medical Staff as a whole. Such changes shall become effective when approved by the Director.

30. **Service Ongoing Professional Practice Evaluation (OPPE)**: Process in which the Service and/or Section Chief conducts ongoing evaluations of a Licensed Independent Practitioner utilizing aggregate data, as available, other service-specific components of clinical competencies, professionalism, and other aspects of a LIP’s performance. At a minimum, ongoing evaluations will be conducted on a semi-annual basis or more frequently as deemed by the Service Chief. The OPPE is protected under The Federal Privacy Act of 1974 5 USC 522 and under VHA Regulations 77VA10Q.

31. **Teleconsultation**: The provision of advice on a diagnosis, prognosis, and/or therapy from a LIP to another LIP using electronic communications and information technology to support the care provided when distance separates the participants.

32. **Telemedicine**: The provision of care by an LIP that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the Provider and the patient.

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

34. **VA Special Fellow**: The term VA Special Fellow refers to a VA-based physician or dentist trainee who has enrolled in a VA Special Fellowship Program for additional training, primarily in research. Special fellowships are non-accredited training programs that are funded directly from the Office of Academic Affiliations in a separate allocation process from residency positions. Physicians in VA Special Fellowships have completed an Accreditation Council for Graduate Medical
Education (ACGME) accredited core residency (Medicine, Surgery, Psychiatry, etc.) and may also have completed an accredited subspecialty fellowship. They are board-eligible or board-certified, and consequently, are licensed independent practitioners. Dentists in VA Special Fellowships have completed a California Dental Association (CDA) accredited residency and are licensed independent practitioners. All VA Special Fellows must be credentialed and privileged in the discipline(s) of their completed (subspecialty-training) programs. VA Special Fellows may function as supervising Practitioners for other trainees.

**ARTICLE I. NAME**

The name of this organization shall be the Medical Staff of the San Francisco Veteran Affairs Health Care System.

**ARTICLE II. VISION, MISSION, VALUES, AND PURPOSE**

**Section 2.01 Vision**

The vision of the Medical Staff is to be the health care provider of choice for veterans.

**Section 2.02 Mission**

The mission of the Medical Staff shall be to:

1. Provide primary through tertiary care that is cost effective and of high quality.
2. Deliver needed care in the most appropriate setting and as near to veterans’ homes as possible.
3. Educate current and future health care professionals.
4. Contribute to health care knowledge through research.
5. Remain a ready resource for Department of Defense (DoD) backup in the event of a national emergency.

The Medical Staff accepts responsibility for the quality of medical care, education, and research provided at SFVAHCS.

**Section 2.03 Values**

1. Trust as the basis for the caregiver-patient relationship and fundamental to all that we do.
2. Respect for the dignity and worth of our patients, their families, our co-workers, and the system in which we are working.
3. Commitment to provide high quality service to our patients, their families, our co-workers and to assume personal responsibility for our individual and collective actions.
4. Compassion for our patients, their families, our co-workers, and all others with whom we are involved.

5. Excellence in all that we do.

6. Communication with our patients, their families, our co-workers, and our community.

7. Innovation to accomplish our vision and mission in new, creative ways.

8. Collaboration in the provision of excellent health care.

The purposes of the Medical Staff shall be to:

1. Assure that all patients treated at SFVAHCS receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.

2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care irrespective of where that care is delivered at SFVAHCS, and are treated by competent practitioners who maintain current licensure. Primary care programs will assure continuity of care and minimize institutional care.

3. Establish and assure adherence to ethical standards of professional practice and conduct.

4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff, delineation of clinical privileges, and defining scopes of practice.

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

6. Maintain a high level of professional performance of Practitioners authorized to practice at SFVAHCS through continuous quality improvement practices and appropriate delineation of clinical privileges.

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

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

9. Develop and implement performance and safety improvement activities in collaboration with the staff, assume a leadership role in improving organizational performance and patient safety, and ensure ongoing implementation of and compliance with current National Patient Safety Goals.

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

11. Establish organizational policy for patient care and treatment and implement professional guidelines from the Under Secretary for Health, VHA.
12. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained.

13. Appropriately document supervision of resident physicians and other trainees.

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

15. Coordinate and supervise the scope of practice of all Advanced Practice Professional and appropriate Allied Health Practitioner staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each Advanced Practice Professional and appropriate Allied Health Practitioner should have a scope of practice statement or privileges as well as the means employed to coordinate and supervise their function with the Medical Staff.

16. Foster a culture that supports each Medical Staff member in accomplishing the functions and responsibilities of the Medical Staff in accordance with the standards of VHA, the SFVAHCS and the Joint Commission, through participation in the development/approval of the Medical Staff Bylaws.

17. Provide patient-centered care.

18. Contribute to new health care knowledge through research.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 3.01 Eligibility for Membership on the Medical Staff

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, all full-time and part-time staff physicians, Dentists, Podiatrists, Optometrists, Nurse Practitioners, Clinical Nurse Specialists, and independently privileged Psychologists under the authority of Title 38 U.S.C. Section 7401, 7405 - 7407, 7402 (a) - (d), Title 5 Code of Federal Regulations 316.402(a), 315.501, 315.502, and other applicable statutes, who continuously meet the qualifications, standards, and requirements of VHA, SFVAHCS, and these Bylaws. Residents who are engaged in Graduate Medical Education and who participate in patient care under the direction of supervising Practitioners are supervised in accordance with VHA Handbook 1400.1, Resident Supervision. Medical Staff membership does not include Advance Practice Professionals and Allied Health Practitioners.

2. Categories of the Medical Staff: Medical Staff membership shall include all staff Practitioners, as described above, but shall not include duly appointed fee basis, without compensation (WOC), and consultant Physicians, Dentists, Podiatrists, Optometrists, and independently privileged Psychologists, Nurse Practitioners, and Clinical Nurse Specialists.

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

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

1. **Criteria for Clinical Privileges**: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit the evidence defined here. Applicants who do not meet these requirements will not be considered. This determination of ineligibility is not considered a denial. Applicants must submit the following:

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

b. **Education applicable to individual Medical Staff members as defined, for example, by holding a Doctoral level degree in Medicine, Osteopathy, Podiatry, Psychology, Optometry, Dentistry, or a Masters or Doctoral degree in Nursing for NPs and CNSs from an approved college or university.**

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

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

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

f. **A completed employment application and complete information consistent with requirements for clinical privileges as defined in Article VII of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff.**

g. **Satisfactory findings about previous professional competence and professional conduct.**

h. **English language proficiency.**

i. **Ability to meet response time criteria established by the SFVAHCS Incident Commander for emergency and disaster situations.**

j. **Faculty appointment in good standing at UCSF School of Medicine for any LIP who will be supervising UCSF medical residents, fellows, or students.**

k. **Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.**
I. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g. driver’s license or passport) and a current Personal Identity Verification (PIV) Card.

2. **Clinical Privileges and Scope of Practice**: While only LIPs may function with defined clinical privileges, not all LIPs are permitted by SFVAHCS and these Bylaws to practice independently.
   
a. The following LIPs will be credentialed and privileged to practice independently:
      i) Physicians
      ii) Dentists
      iii) American Psychological Association (APA) Psychologists
      iv) Optometrists
      v) Podiatrists
      vi) Nurse Practitioners
      vii) Clinical Nurse Specialists

b. The following Practitioners will be credentialed and will practice under a Scope of Practice with appropriate supervision:
   
i) Physician Assistants (PAs)
   ii) Certified Registered Nurse Anesthetists (CRNAs)
   iii) Clinical Pharmacy Specialist

c. The following Allied Health Practitioners (AHPs) will be dependently credentialed and will practice under a functional statement with appropriate supervision.
   
i) Dietitians
   ii) Audiologists and Speech Pathologists
   iii) Occupational and Physical Therapists
   iv) Social Workers
   v) Pharmacists (not clinical)
   vi) Registered Dental Hygienists

3. **Change in Status**: Members of the Medical Staff as well as all Practitioners practicing through privileges or a scope of practice must agree to provide care to patients within the Scope of Practice and advise the Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership, to carry out clinical privileges which are held, and any changes in the status of professional credentials, such as, but not limited to, loss of licensure, clinical privileges, or certification, as well as any pending or proposed action against a credential, such as, but not limited to, licensure, clinical privileges, certification, professional organization or society, as soon as able, but no longer than 15 days after notification of the Practitioner.
Section 3.03 Code of Conduct

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

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

Behavior or Behaviors That Undermine a Culture of Safety: a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients, and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that behavior or behaviors that undermine a culture of safety are often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, these behaviors may reach a threshold that constitutes grounds for further inquiry by the MEC into the potential underlying causes of such behavior. Behavior or behaviors that undermine a culture of safety by a Provider could be grounds for disciplinary action.
VA distinguishes behavior or behaviors that undermine a culture of safety from constructive criticism that is offered in a professional manner with the aim of improving patient care. VA also reminds its Providers of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a Provider’s health and performance. Providers suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

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

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

**Section 3.04 Basic Responsibilities of Medical Staff Membership**

Medical Staff Members must fulfill the following Basic Responsibilities:

1. To provide patient care at a professionally recognized level of quality and efficiency.

2. To observe and protect patients' rights in all patient care activities.

3. To actively participate in continuing education, peer review, Medical Staff monitoring and evaluation, and organizational quality improvement activities.

4. To maintain standards of ethics and ethical relationships including a commitment to:
   
a. Abide by Federal law and VA rules and regulations regarding financial conflict of interest and outside professional activities for remuneration.

b. Provide care to patients within the scope of approved privileges and advise the Medical Center Director, through the Chief of Staff, of any change in ability to fully meet the criteria for Medical Staff membership or to execute approved clinical privileges.

c. Advise the Medical Center Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of such occurrences consistent with requirements under Article VIII of these Bylaws.

d. Contribute to, and abide by, high standards of ethics in professional practice and conduct.
e. Disclose adverse events to patients or their representatives in keeping with SFVAHCS Medical Center Memorandum (MCM) Number (No.) 11-72, “Informing Patients about Adverse Events” and VHA Directive 2005-049.

f. Report unsafe practices and unusual occurrences through the SFVAHCS Incident Reporting System as outlined in MCM No. 11-51, “Patient Safety Program.”

5. To contribute to the development of, and abide by, the Medical Staff Bylaws and Rules and all other lawful standards and policies of VHA and the SFVAHCS.

6. To provide appropriate supervision of trainees as applicable to the care setting in accordance with MCM No. 11-22, “Resident Supervision.”

Section 3.05 Medical Staff Leadership in Performance Improvement Activities

The organized Medical Staff provides leadership for the measurement, assessment, and improvement of the following areas:

1. Medical assessment and treatment of patients

2. Use of medications

3. Use of blood components

4. Operative and other procedures

5. Appropriateness of clinical practice patterns

6. Use of developed criteria for autopsies

7. Sentinel event data

8. Patient safety data

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. Composition:
   a. Chief of Staff

2. Qualifications:
   a. The Chief of Staff must meet the qualification standards established for his or her profession in accordance VA Handbook 5005, which include, but are not limited to:
      i) Board Certification
ii) Full, active, current, and unrestricted license to practice medicine or dentistry in a state, territory, or commonwealth of the United States, or the District of Columbia

iii) Physical standards established by VA Handbook 5019

iv) Proficiency in spoken and written English as required by 38 USC 7402(d) and 7407(d)

v) Any additional skills and competencies as defined by SFVAHCS Leadership

3. Selection:
   a. Based on a nomination by the Medical Center Director and the Dean of UCSF School of Medicine, the Network Director approves recommendations to the position of Chief of Staff. The selecting organization is responsible to complete and submit the information on the selectee to the Leadership Management and Succession Sub-Committee (LMSS) The LMSS support staff (Executive Recruitment Team) in the Workforce Management and Consulting Office will submit templates to the Leadership Management and Succession Sub-Committee and Workforce Committee for information only.

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

5. Duties:
   a. The Chief of Staff is the senior administrative physician in charge of professional services. The Chief of Staff plans, directs, and coordinates activities of the clinical professionals, has direct responsibility for organization and administration of the Medical Staff, and for proper functioning of the clinical organization. The Chief of Staff is directly responsible to the SFVAHCS Director for the quality of professional care provided in the facility. The Chief of Staff shall:
      i) Function as the President of the Medical Staff, organize and preside over annual meetings of the Medical Staff, and assure that Medical Staff Committees and Services function in accordance with these Bylaws and Rules.
      ii) Review initial and renewal credentialing and privileging (C&P) files and forward all clean files and recommendations to the Medical Center Director for review and approval.
      iii) Forward Professional Standards Board (PSB) recommendations that may have adverse credentialing and/or privileging issues to the Service Chief for review.
      iv) Forward recommendations on any initial or renewal files that have credentialing and/or privileging issues to the Medical Center Director for review and final action.
v) Serve as Chairperson of the following Committees/Boards: Medical Executive Committee (MEC) Peer Review Committee, Clinical Chiefs Committee and serves as a member on multiple committees.

vi) Collaborate with the Medical Center Director and the Deputy Director in the planning, direction, coordination, and supervision of administrative activities inherent in the care of patients, in providing allied health services, and in research and educational activities.

vii) Enforce Medical Staff Bylaws, applicable VHA regulations and Medical Center policies, taking any corrective action as indicated.

viii) Supervise and/or participate in the appointment and periodic reappraisal of members of the Medical Staff, Advanced Practice Professionals, and Allied Health Practitioners, including credentialing and delineation of clinical privileges and review of all scopes of practice.

ix) Represent the views, policies, needs, and grievances of the Medical Staff to the Medical Center Director, Veterans Integrated Service Network (VISN) 21 Network Director, and the VISN 21 Chief Medical Officer (CMO).

x) Disseminate information from MEC and Clinical Chiefs to all Attending Staff and House Staff as appropriate.

Section 4.02 Leadership and Officers

1. Leadership:
   a. The Chief of Staff functions as the President of the Medical Staff, organizes and presides at annual meetings of the Medical Staff, and assures the various other Medical Staff Committees and services function in accordance with these Bylaws and Rules.
   b. The Organized Medical Staff, through its committees, boards, teams, services and Service Chiefs, provides counsel and assistance to the Chief of Staff and Director regarding all facets of patient care, treatment, and services, including evaluating and improving the quality and safety of patient care services and the development of goals congruent with the facility mission and vision.
   c. All members of the Medical Staff are eligible for membership on the Executive Committees of the Medical Staff.

2. Officers:
   a. VA has no requirement for officers of the Medical Staff. The Chief of Staff functions as President of the Medical Staff. Proposals to remove the President of the Medical Staff will be handled in accordance with applicable VHA policy as outlined in VA Handbook 5021, Part II and directed to and coordinated through the Medical Center Director.

Section 4.03 Clinical Services

1. Characteristics:
a. Clinical Services are organized to provide clinical care and treatment under leadership of a Service Chief or Associate Chief of Staff (ACOS) and include:

i) Anatomic Pathology

ii) Anesthesia

iii) Chaplain

iv) Clinical Informatics

v) Dental & Oral and Maxillofacial

vi) Dermatology

vii) Education

viii) Medicine

ix) Geriatrics and Extended Care

x) Neurology

xi) Laboratory Medicine

xii) Mental Health

xiii) Nutrition and Food

xiv) Pharmacy

xv) Primary Care

xvi) Radiology

xvii) Rehab

xviii) Surgery

xix) Research

xx) Social Work

b. Clinical Services hold service-level meetings at least quarterly.

2. Functions:

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

b. Assist in identification of important aspects of care for the Service, identification of indicators used to measure and assess important aspects of care, and evaluation of the quality and appropriateness of care.

c. Utilize VHA performance measures and monitors as a basis for assessing the quality, timeliness, efficiency, and safety of Service activities, and conduct
continuous assessment and implementation of current National Patient Safety Goals.

d. Conduct regular service meetings and maintain records of meetings that include reports of discussion of issues, problems, conclusions, data, recommendations, responsible person, actions, actions taken, an evaluation of effectiveness of actions taken, and follow-up. Quality Improvement (QI) reports are to be forwarded in a timely manner through channels established by the Medical Staff, at a minimum on a quarterly basis.

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

f. Define and/or develop clinical privilege statements including levels (or categories) of care that physicians in their individual services are competent to perform, which include all requirements of VHA Handbook 1100.19.

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

h. Annually review privilege templates for each Service and make recommendations to the Medical Executive Committee.

i. Those Services that participate in training programs will adhere to MCM No. 11-22, “Resident Supervision,” 11-24, “Health Care Provider Orders,” and 11-32, “Medical Students,” in providing supervision of students, interns, residents, or fellows.

j. For those Services that conduct operative or invasive procedures, processes measured for performance improvement encompass some or all of the following: (1) selecting appropriate procedures, (2) preparing the patient for the procedure, (3) performing the procedure and monitoring the patient, and (4) providing for post-procedure care and postoperative patient education. Procedures selected for monitoring on a continuous basis include those that affect a large percentage of patients, and/or place patients at serious risk, and/or have been or are likely to be problem prone. Sentinel events are reviewed in a timely manner.

k. For those services that handle, prescribe, and administer medications, processes measured for performance improvement encompass any or all of the following: (1) prescribing or ordering, (2) preparing and dispensing, (3) administering, and (4) monitoring the medications’ effect on patients. Medications selected for monitoring on a continuous basis include those that affect a large percentage of patients, and/or place patients at serious risk if not administered when needed or administered when not needed, are high cost, and/or problem prone. Findings from processes measured should be forwarded to the Pharmacy & Therapeutics Committee for discussion. Sentinel events are reviewed in a timely manner.

l. For those services that handle, prescribe, and administer blood/blood products, processes measured for performance improvement encompass any or all of the following: (1) ordering, (2) distributing, handling, and dispensing, (3) administering, and (4) monitoring the blood and blood components’ effects on
patients. Products selected for measuring on a continuous basis can be sampled for high volume cases. When this is done, an appropriate statistically valid sample size is determined and used. Sentinel events are reviewed in a timely manner.

3. **Selection and Appointment of Service Chiefs**: The Medical Center Director appoints Service Chiefs based upon the recommendation of the Chief of Staff.

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

   a. Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

   b. Clinically related activities of the Service.

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

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

   e. Notifying the PSB through the Chief of Staff about a privileged Practitioner with alleged deficiencies in professional performance.

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

   g. Recommending clinical privileges for each member of the Service.

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

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

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

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

   l. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service, including recruiting appropriate members to the Service.

   m. The determination of qualifications and competence of Service personnel who are not LIPs and who provide patient care, treatment, and services
n. The continuous assessment and improvement of the quality of care, treatment, and services

o. Developing and implementing a service quality improvement plan

p. Continuously implementing and assessing compliance with current and applicable National Patient Safety Goals

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

r. The orientation and continuing education of all persons in the Service

s. The assurance of space and other resources necessary for the Service defined to be provided for the patients served

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

u. Assessing all initial and/or renewal Practitioner credentialing documents and completing the VetPro Service Chief appointment screen. This process must be done before the packets are presented to the PSB.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.

2. All committee members, regardless of whether they are members of the Medical Staff, are eligible to vote on committee matters, unless otherwise set forth in these Bylaws or applicable MCM. A vote to abstain is not considered a vote and should not be used unless there is a conflict of interest or perceived conflict of interest.

3. The presence of 50% of a committee’s members plus one will constitute a quorum, unless otherwise provided for in an applicable MCM.

4. The members of all standing committees, other than the MEC, are subject to approval by the Medical Center Director, unless otherwise stated in these Bylaws or applicable MCM.

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

Section 5.02 Executive Committee of the Medical Staff

1. Characteristics: The Medical Executive Committee serves as the Executive Committee of the Medical Staff. The chairperson is the Chief of Staff.

a. The membership is as follows:

Voting Members
1. Following Service Chiefs: Medicine, Surgery, Anesthesia, Radiology, Neurology, Dental, Dermatology, Anatomic Pathology, Laboratory Medicine, Primary Care
2. Deputy Chief of Staff
3. ACOS Mental Health Services
4. ACOS Geriatrics & Extended Care
5. ACOS Education
6. ACOS Research
7. ACOS Clinical Informatics
8. Chief, Emergency Department
9. Nurse Executive

Non-Voting Members

1. Chief, Quality Management
2. Chair, Pharmacy & Therapeutics Committee
3. Chief, Pharmacy
4. Chief, Nutrition and Food
5. Chief, Rehab Services
6. Chief, Social Work
7. Chief, Chaplain Services
8. Chief, Infectious Diseases
9. Chief, Pulmonary & Critical Care Medicine
10. Chief, Cardiology Section
11. Director of Ambulatory Care
12. Deputy Nurse Executive
13. Chair, Peer Review Committee
14. Patient Safety Manager
15. Chief Nurse, Ambulatory Care
16. Clinical Contracts Coordinator
17. Manager for Peer Review, Quality Management
18. Chief Nurse, Mental Health and Critical Care Services
19. Chief Nurse, Surgical and Specialty Care
20. Chief Nurse, Ambulatory Care, Primary Care, Telehealth, HDU
21. Chief, Advanced Practice Nursing
22. Chief Nurse, Specialty Care

b. The majority of the voting members must be fully licensed physicians of medicine or osteopathy actively practicing in the hospital, but it may include other practitioners and any other individuals as determined by the organized Medical Staff.

c. Selection process for membership: Members of the Medical Executive Committee are selected based on function. Active staff who function as ACOS and/or Chief are members of the MEC as well as those Section Chiefs and Chiefs of committees listed in 1a above.
d. Removal process for membership: Resignation from the functions described above results in automatic termination of the membership, unless a request is made by the Chair of the MEC.

2. Functions of the Medical Executive Committee: The MEC serves as an advisory and recommending body to the Medical Center Director on clinical issues affecting the medical center and patient care. The MEC represents and acts on behalf of the Medical Staff in the intervals between meetings of the Medical Staff, subject to such limitations as may be imposed by these Bylaws and Rules. The MEC oversees process for addressing instances in which there is “for-cause” concern (substandard care, professional incompetence or professional misconduct) related to a medical staff member’s competency to perform the requested or held privileges. The functions and responsibilities of the MEC are further defined in MCM No. 00-09, “Medical Executive Committee.” The Professional Standards Board is a session of the Medical Executive Committee, which meets bi-monthly (at least 18 times per year) and is charged to review and act on matters concerning appointments, advancements, and make appropriate recommendations to MEC in regard to clinical privileges. The session is described in MCM No. 00-09, “Professional Standards Board.” The MEC makes recommendations directly to the Director regarding the organization, membership (selection and termination), structure, and function of the Medical Staff.

3. Meetings:

   Regular Meetings: Regular meetings of the MEC shall be held bi-monthly (at least 18 times a year). Additional meetings will be held as needed to ensure that committee responsibilities are met. The date and time of the meetings shall be established by the Chair for the convenience of the greatest number of members of the Committee. The Chairmen of the various committees of the Medical Staff shall attend regular meetings of the MEC when necessary to report the activities and recommendations of their committees; and may attend at other times with the consent of the Chief of Staff. Such attendance shall not entitle the attendee to vote on any matter before the MEC.

   a. Meeting Notice: All MEC members shall be provided at least 48 hours advance written notice of the time, date, and place of each regular meeting and reasonable notice, oral, or written, of each emergency meeting.

   b. Agenda: The Chief of Staff, or in his or her absence, his or her designee, shall chair meetings of the MEC. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.

   c. Quorum: A quorum for the conduct of business at any regular or emergency meeting of the MEC shall be a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present.

   d. Minutes: Minutes of meetings will be prepared and maintained by the Chief of Staff’s Office and will include the names of attendees, a report of discussions,
conclusions, actions, and recommendations, and/or follow-up actions or monitoring as indicated. These minutes will be submitted to the Director for review, comment, and approval, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff.

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

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

Section 5.03 Committees of the Medical Staff

1. Standing Committees are established for the purpose of (a) evaluating and improving the quality of health care rendered, (b) reducing morbidity or mortality from any cause or condition, (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds, (d) reviewing the professional qualifications of applicants for Medical Staff membership, (e) reviewing the activities of the Medical Staff and Advanced Practice Professionals and Allied Health Practitioners, (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners, and (g) for such additional purposes as may be set forth in the charges to each committee. These committees are listed in the Medical Executive Committee MCM 00-09 and are subject to change as the MCM is updated.

2. Information Flow to Medical Executive Committee: Peer Review for Quality Management Committee and Surveillance, Prevention & Control of Infection Committee will submit a quarterly report to the MEC and such other reports and documents as required and/or requested by the MEC.

Section 5.04 Committee Records and Minutes

1. Committees prepare and maintain minutes that may include data, conclusions, recommendations, responsible person(s), actions taken, and evaluation of results of actions taken. These minutes are to be forwarded in a timely manner in accordance with the applicable MCM.

2. Each Committee provides appropriate and timely feedback to Leadership as provided for in the applicable SFVAHCS Medical Center Memorandum.
Section 5.05 Establishment of Committees

1. The MEC may establish additional standing or special committees to perform one or more Medical Staff functions by resolution and upon approval of the Director and without amendment of these Bylaws.

2. The MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions by resolution and upon approval of the Director.

ARTICLE VI. MEDICAL STAFF MEETINGS

1. **Regular Meetings:** Regular meetings of the Medical Staff shall be held at least annually.

2. A record of attendance shall be kept.

3. **Special Meetings:** Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the MEC. At any such meeting, only that business set forth in the notice thereof will be transacted. Notice of any such meeting shall be deemed sufficient if it is given in writing to the Medical Staff at least 48 hours prior thereto. Members of the Medical Staff may request a special meeting either through the Chief of Staff or Director in writing and stating the reason(s) for the request.

4. **Quorum:** For purposes of Medical Staff business, 25% of voting members constitutes a quorum.

5. **Meeting Attendance:** Members of the Organized Medical Staff should attend their Service staff meetings and meetings of committees of which they are members unless specifically excused by the Service Chief for appropriate reasons, e.g., illness, leave, or clinical requirements.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. **Independent Entity:** SFVAHCS is an independent entity, granting privileges to the Medical Staff through the MEC and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff and Advanced Practice Professional, and reappointments may not exceed two years, minus one day from the date of last appointment or reappointment date. Medical Staff and Advanced Practice Professionals must practice under their privileges, scope of practice, or functional statement.

2. **Credentials Review:** All LIPs and all Advanced Practice Professionals who hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment, reappraisal for granting of clinical privileges, and after a break in service. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. LIPs and Advanced Practice Professionals are appointed for a maximum period of two years.
3. Deployment/Activation Status:
   a. The privileges will be placed in a “Deployment/Activation Status,” and the credentialing file will remain active with the privileges in this status when a member of the Medical Staff has been deployed to active duty and upon notification of the deployment. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Provider will update the credentialing file to current status, including answering the standard Supplemental Questionnaire updating licensure information, health status, and professional activities while on active duty.
   b. The Medical Staff Office (MSO), in accordance with VHA policy and Joint Commission Accreditation Standards, will confirm the updated information and submit it to the PSB for recommendation and approval to restore the Provider’s privileges to Current and Active Status from Deployment/Activation Status. In this circumstance, the date of the original clinical privileges will continue to be the date of the restored clinical privileges.
   c. In those instances where the privileges lapsed during the call to active duty, the Provider must provide additional references or information needed for verification, and all verifications must be completed prior to reappointment.
   d. In those instances where the Provider was not providing clinical care while on active duty, the Provider in cooperation with the Service Chief must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges should be initiated on a short-term basis. These Providers may be returned to a pay status, but may not be in direct patient care.
   e. The service chief and Medical Executive Committee should consider putting a FPPE in place to confirm clinical current competence depending upon the length of time away from the facility or other circumstances.

4. Employment or Contract: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:
   a. Provisions of 38 USC 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment,
   b. Federal law authorizing VA to contract for health care services.

5. Focused Professional Practice Evaluation:
   a. The FPPE is a process whereby the Medical Staff evaluates the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This occurs with a new Practitioner or an existing Practitioner who requests a new privilege and when there is a “for-cause” event. The performance monitoring process is defined by each Service and must include:
      i) Criteria for conducting performance monitoring.
ii) Criteria for determining the type of monitoring to be conducted.

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

iv) Method for determining the duration (time or volume based) of the performance monitoring.

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

vi) Method/Benchmarks for reporting successful completion of FPPE to be reported through the Medical Executive Committee for closure of FPPE and transition to OPPE.

b. Information resulting from the FPPE process will be integrated into the service specific performance improvement program (non-Title 38 U.S.C. 5705 protected process), consistent with the Service’s policies and procedures.

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

i) Extension of FPPE review period.

ii) Modification of FPPE criteria.

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

iv) Revocation or Reduction of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately managed through Employee Relations and, if a physician or dentist, reported to the National Practitioner Data Bank).

d. The FPPE process is required for all providers, including Physician Assistants and Clinical Pharmacy Specialists, who are on scopes of practice but are credentialed in accordance with VHA Handbook 1100.19, “Credentialing and Privileging” and Medical Staff Bylaws.

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

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

ii) If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply the same processes to the evaluation of individuals employed under provision of 38 USC 7405 and those utilized under contracts and sharing agreements. This mandatory probationary review is separate and distinct from the FPPE, which may or may not be necessary.
6. **Ongoing Professional Practice Evaluation:**

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

   i.) The timeframe for the Service OPPE is every six months. The Service OPPE will be summarized in the Biennial OPPE form and completed by the Service Chief at the time of re-credentialing.

   ii.) The process that facilitates the evaluation of each practitioner’s professional practice will be clearly defined.

   iii.) The type of data to be collected during the OPPE is determined by Service and approved by the organized Medical Staff.

   iv.) With very few exceptions, VHA data standing alone is not protected by 38 USC 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 USC 5705. Data that is not previously identified as protected by 38 USC 5705 and is collected as Provider-specific data could become part of a Practitioner’s Provider profile, analyzed in the facility’s defined on-going monitoring program, and compared to pre-defined facility triggers or de-identified quality management data. The Provider profile is protected by the Privacy Act System of Records 77VA10Q.

   v.) In those instances where a Practitioner does not meet established criteria, the Service Chief has the responsibility to document these facts. These situations can occur for a number of reasons and do not preclude a Service Chief recommending the renewal of privileges, but the Service Chief must clearly document the basis for the recommendation of renewal of privileges. When appropriate, the Service Chief will use the FPPE process to address competency concerns.

   vi.) The MEC must consider all information available, including the Service Chief’s recommendation and reasons for renewal when criteria have not been
met, prior to making their recommendation for the granting of privileges to the Director. This deliberation must be clearly documented in the minutes.

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

7. Non-Discrimination Policy: Appointment to the Medical Staff and/or the grant of Clinical Privileges shall not be approved or denied on the basis of an individual’s gender, age, creed, religion, color, national origin, or disability.

Section 7.02 Application Procedures

1. Completed Application: Applicants for appointment to the Medical Staff must submit a complete employment application and be prepared to submit to random drug testing. The applicant must submit credentialing information through the VHA’s electronic credentialing system as required by VHA guidelines. The applicant is bound to be forthcoming, honest, and truthful (See VHA 1100.19 page 9). To be complete, applications must include authorization for release of information pertinent to the applicant and the information listed below. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy, if the Practitioner says the information provided is factually incorrect. The Application requirements include:

a. Items specified in Article III, Section 2, Qualifications for Medical Staff Membership, including:
   i) Active, Current, Full, and Unrestricted License
   ii) Education
   iii) Relevant training and/or experience
   iv) Current professional competence and conduct
   v) Physical and Mental health status
   vi) English language proficiency
   vii) Professional liability insurance (contractors only)
   viii) Evidence of current Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS) training as appropriate to assignment. Prior to assuming clinical duties, new providers must supply evidence of current certification in BLS and ACLS as required by VHA policy. Provider must maintain certification in order to continue provision of clinical duties as required by VHA policy.
ix) The Practitioner must have specific, approved clinical privileges that necessitate moderate sedation and airway management as a prerequisite for being granted moderate sedation and airway management privileges. The Practitioner will acknowledge that he/she has received a copy of “The Sedation and Analgesia by Non-Anesthesia Providers” policy and agrees to the guidelines outlined in the policy. See MCM No. 11-14, “Sedation and General Anesthesia by Non-Anesthesiologists during Diagnostic and Therapeutic Procedures” for more detailed information.

x) Continuing Medical Education (CME) that meets the Medical Board of California requirements for licensure renewal and the requirements of their state license board. All SFVAHCS physicians, regardless of state of licensure, will comply with the California Board requirement of an average of 25 hours of approved Category 1 or other acceptable CME each calendar year for a total of 100 approved hours over a four-year period as stated in the California Code of Regulations, Title 16, Chapter 13, Article 11. The CME must be related to the area and scope of clinical privileges and taken during the two-year period being examined for reappraisal. Nurse Practitioners and Clinical Nurse Specialists must meet and maintain the continuing education requirements as specified by the state under which they are licensed and the requirements of their individual board certification. The continuing education and board certification must be related to the area and scope of clinical privileges and meet the time-lines as delineated by the state licensure and national board certification of the Nurse Practitioner or Clinical Nurse.

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

c. **References**: The names and addresses of a minimum of four individuals who are qualified to provide authoritative information regarding training/experience, current clinical competence, health status, and/or fulfillment of obligations as a Medical Staff member within the privileges requested are required. At least one of the references must come from the current or most recent employer. In the case of individuals completing residencies, one reference must come from the residency program director. The Director may require additional information.

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

i) Name of health care institution or practice.

ii) Term of appointment or employment and reason for departure.
iii) Privileges held and any disciplinary actions taken or pending against privileges, including suspension, revocation, limitations, or voluntary and/or involuntary surrender.

e. Drug Enforcement Administration (DEA)/Controlled Substance Number (CDS) Registration: A description of:

i) Status, either current or inactive.

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

iii) All practitioners who are authorized by their State licensing authority to prescribe controlled substances are required to possess a personal independent Drug Enforcement Administration (DEA) registration number that is registered in California.

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

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

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

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

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

k. Picture Identification: Picture identification to ensure that he/she is the individual identified in the credentialing documents.

l. Primary Source Verification: SFVAHCS obtains primary source verification in accordance with VHA Handbook 1100.19 Credentialing and Privileging and VA Handbook 5005, Part II, Chapter 3. Prior to granting initial privileges, the SFVAHCS will obtain primary source verification of the following:

i) A minimum of three references for initial credentialing and two for re-credentialing from individuals able to provide authoritative information regarding information as described in Article III.

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

iii) Verification of status of all licenses current and previously held by the applicant.
iv) Evidence and verification of the Educational Commission for Foreign Medical Graduates (ECFMG) certificate for foreign medical graduates, if claimed.

v) Evidence and verification of board certification or eligibility, if applicable

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

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

viii) For all physicians, screening will be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner is required. Screening will also include the NPDB. For all Nurse Practitioners and Clinical Nurse Specialists primary source verification from the State Licensing Board for all licenses held by the Nurse Practitioner or Clinical Nurse Specialist will be accomplished, including any or all actions related to any disciplinary alert found. Any disciplinary action from a current or previous license will require a statement from the Practitioner.

ix) Confirmation of health status on file as documented by a physician, NP, or CNS approved by the Organized Medical Staff.

x) Evidence and verification of the status of any alleged or confirmed malpractice.

xi) The applicant’s agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws and Rules for the SFVAHCS.

2. The applicant must attest to the accuracy and completeness of the information submitted.

3. The applicable must submit information regarding other potential risk events.

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

5. **VetPro Required:** All healthcare Providers must submit credentialing information into VetPro as required by VHA policy. VetPro is VHA’s secure, on-line Federal Credentialing Program application. Access to and instructions for completing VetPro will be granted to the applicants by the MSO once written notification has
been received from the appropriate Clinical Service Chief and approved by the Chief of Staff.

Section 7.03 Process and Terms of Appointment

Appointments, re-appointments, denials, and revocations of appointments to the Medical Staff shall be made by the Medical Center Director with recommendations from the Chief of Staff, Chief of Service, and MEC, as described below:

1. **Peer Recommendation**: Peer recommendations will be obtained from individuals who can provide authoritative information regarding training/experience, professional competence, conduct, and health status.

2. **Initial Privileges**: Recommendation for initial privileges will be based on the determination that the applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references regarding professional competence, and health status.

3. **Chief Medical Officer Review**: In order to ensure an appropriate review is completed in the credentialing process the applicant’s file must be submitted to the VISN 21 CMO for review and recommendation as to whether to continue the appointment and privileging process prior to presentation to the MEC if the response from the National Practitioner Data Bank (NPDB) query indicates that any of the following criteria are met: There have been, for or on behalf of the applicant, (a) three or more medical malpractice payments, (b) a single medical malpractice payment of $550,000 or more, or (c) two medical malpractice payments totaling $1,000,000 or more. The higher level review by the VISN 21 CMO is to assure that all circumstances, including the individual’s explanation of the specific circumstances in each case, are weighed against the primary source verification and that the appointment is still appropriate. The VISN 21 CMO may consult with Regional Counsel as needed to determine the appropriate documents for primary source verification of the basis for medical malpractice payments. The VISN 21 CMO review will be documented on the Service Chief’s Approval screen in VetPro as an additional entry. Review by the VISN 21 CMO is also required for applicants for initial appointment who have had any licensure actions or may have any pending licensure actions.

4. **Chief of Service Recommendation**: The Chief of the Service or equivalent responsible person, in coordination with the MSO, is responsible for recommending appointment to the Medical Staff based on evaluation of the applicant’s completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met. The Clinical Service Chief in coordination with the MSO shall submit completed initial credentialing and privileging packets to the PSB session of the MEC for review with a recommendation for approval or denial of membership to the Medical Staff.

5. **Medical Executive Committee Recommendation**: The PSB session of the MEC recommends Medical Staff appointment to the Director based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
6. **Director Action**: Final approval is the responsibility of the Medical Center Director, based on evaluation of the credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met. Recommended appointments to the Medical Staff are reviewed by the Chief of Staff and should be acted upon by the Director within 30 calendar days of receipt of a fully complete application, including all required verifications, references, and recommendations from the appropriate Service Chief and MEC.

7. **Grade and Step**: After approval of an applicant’s initial credentialing and privileging packet, and Ad Hoc PSB, the Chief of Staff’s Office forms a pay panel to determine the grade/step and salary of the applicant in accordance with Local VISN-level Compensation Panels, as described in Article VII, Section 7.05. Grade and Step for Nurse Practitioners and Clinical Nurse Specialists is determined by the Nurse Professional Standards Board.

8. **Applicant Informed of Status**: Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice from HRMS of appointment or non-appointment, or return of the application because of inadequate information. If the appointment is not approved, reasons will be provided to the applicant. The applicant has no right to a hearing or appellate review pursuant to these Bylaws. However, other avenues of appeal may be available under Federal law.

9. **SFVAHCS Dean’s Committee**: All new appointments to the Medical Staff will be reviewed and approved at the quarterly meeting of the SFVAHCS Dean’s Committee.

### Section 7.04 Credentials Evaluation and Maintenance

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

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

3. **Maintenance of Files**: A complete and current C&P file including the electronic VetPro file will be established and maintained by the MSO for each Provider requesting privileges. Maintenance of the C&P file is the responsibility of the
Director or designee. Any time a file is found to lack required documentation, without an entry as noted above in paragraph 2 describing the efforts made to obtain the information, effort will be made to obtain the documentation.

4. **Focused Professional Practice Evaluation:** A FPPE will be initiated at time of initial appointment with privileges, if prior competence at SFVAHCS is not known at the time of request for additional privileges, or in case of a “for-cause” event requiring a focused review. The FPPE will be consistently implemented in accordance with the criteria and requirements defined by the organized Medical Staff.

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

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

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

d. The FPPE monitoring process will clearly define and include the following:
   i) Criteria for conducting the FPPE.
   ii) Method for monitoring for specifics of requested privilege.
   iii) Statement of the “triggers” for which a “for-cause” FPPE is required.
   iv) Measures necessary to resolve performance issues which will be consistently implemented.

e. Information resulting from the FPPE process will be integrated into the Service specific performance improvement program (non-Title 38 USC 5705 protected process), consistent with the Service’s policies and procedures.

f. If at any time the Service Chief or designee cannot determine the competence of the Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:
   i) Extension of FPPE review period.
   ii) Modification of FPPE criteria.
   iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner).
   iv) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and any termination will be conducted in accordance with SFVAHCS policy and reported appropriately).
Section 7.05 Local/VISN-Level Compensation Panels

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

ARTICLE VIII. CLINICAL PRIVILEGES

Section 8.01 General Provisions

The organized Medical Staff is responsible for planning and implementing the privileging process. The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidenced-based process. Medical Center facility specific privilege forms are reviewed on an annual basis by the Service Chief, reviewed and recommended for approval by the PSB session of the MEC and given final approval by the Medical Center Director. All clinical privileges are setting-specific. The Clinical Service Chief or designee is responsible for determining the setting of each applicable clinical privilege.

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

2. Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

3. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges, and will be accomplished utilizing the VetPro system as done at the time of initial application. Reappraisal is initiated by the MSO once the need for renewal of clinical privileges has been confirmed by the Practitioner’s Clinical Service Chief. Reappraisal includes, but is not limited to, a review of performance, evaluation of the individual’s physical and mental status, and competency assessment based on the individual’s requested privileges. Service-specific ongoing Practitioner data contained in the Service’s Provider profiles will be utilized as a component of the review process. Renewal documents will also contain documentation of continuing medical education that complies with California state licensure renewal requirements or the requirements of the state licensure and board certification of the Nurse Practitioner or Clinical Nurse Specialist.

   a. Although the reappraisal process occurs biennially, the Service OPPE is designed to continuously evaluate a Practitioner’s performance.

   b. Reappraisal requires verification of satisfactory completion of sufficient continuing education to satisfy state licensure and Medical Staff requirements.

   c. For initial and reappointment, all time-limited credentials, including peer appraisals must be current within 180 days of submission of the application. The term current applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate’s application and appointment, reappointment or reporting for duty is greater than
180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the MEC. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (See VHA 1100.19).

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

5. Advanced Practice Professionals, including CRNAs, Clinical Pharmacy Specialists and PAs, who are permitted by law and the facility to provide patient care services may be granted scope of practice, clinical privilege and/or prescriptive authority based on their assignments, responsibilities, qualifications, and demonstrated competence.

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

7. Practitioners with clinical privileges are approved for and have clinical privileges in one Clinical Service but may be granted clinical privileges in other Clinical Services. Clinical privileges granted extend to all physical locations of the designated Service(s) within the jurisdiction of the organization and its patient service area. In those instances where clinical privileges cross to a different designated service, all Service Chiefs must recommend the practice.

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

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

10. Approved clinical privilege documents are placed in the individual Practitioner’s C&P file. Copies are provided to the Practitioner, Clinical Service Chief, and the clinical areas where the Practitioner practices.

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

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

1. **Burden of Proof:** The Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.

2. **Requests in Writing:** All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.

3. **Credentialing Application:** The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
   a. Complete appointment information as outlined in Section 7.02 of Article VII.
   b. Application for clinical privileges as outlined in this Article.
   c. Evidence of professional training and experience in support of privileges requested.
   d. A statement of the Practitioner’s physical and mental health status as it relates to Practitioner’s ability to function within privileges. This must be confirmed by a Physician, Nurse Practitioner, or Clinical Nurse Specialist acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEC.
   e. A statement of the current status of all licenses and certifications held.
   f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits, or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
   g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.
   h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.
   i. Prior to assuming clinical duties, new providers must supply evidence of current certification in BLS and/or ACLS as required by VHA Policy. Provider must
maintain certification in order to continue provision of clinical duties as required by VHA Policy.

4. Initial Credentialing:

a. All Practitioners who are new to the SFVAHCS will be proctored by their service utilizing a Focused Professional Practice Evaluation form.

b. The Practitioner’s ability to perform privileges requested must be documented in their credentials file. VHA Handbook 1100.19 requires a signed health statement indicating that no health problems exist that could affect the Practitioner’s practice and this is confirmed by their new Service Chief. When applicant’s ability (based on health) to perform privileges is in doubt, an evaluation by an external and/or internal source may be required.

c. The PSB session of MEC will recommend approval or denial of the Practitioner’s request for clinical privileges based upon a review of the applicant’s education, training, experience, demonstrated competence, references, and other relevant information. The PSB shall recommend approval or denial of the clinical privileges as well as any need for proctoring and/or professional performance monitoring to the Chief of Staff and the Medical Center Director for final review and action.

d. A Practitioner’s Clinical Service Chief and/or Section Chief or designee will review and sign-off on clinical privileges. If clinical privileges are requested for other services and/or settings, the Service and/or Section Chief or designee in those settings must review and sign-off on the requested privileges.

e. The Clinical Service Chief or designee will be responsible for assigning a proctor for those Practitioners requesting initial clinical privileges or Providers who are determined to need a focused review assessment of ability to deliver safe, high-quality patient care. The PSB may also recommend to the Service Chief a period of proctoring for those Practitioners who may need to gain competency prior to being granted a certain category of clinical privilege(s).

5. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with these Bylaws and Rules. This attestation must be made in VHA’s electronic credentialing system before the provider can submit their application for appointment or privileges. If the Bylaws are updated between credentialing cycles the practitioners will be notified electronically with a read receipt, which would be considered their attestation.

6. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that he/she has received a copy of Sedation and Analgesia by Non-Anesthesia Providers policy and agree to the guidelines outlined in the policy. See MCM No. 11-14, “Sedation and General Anesthesia by Non-Anesthesiologists during Diagnostic and Therapeutic Procedures” for more information.
Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

1. **Application**: The Practitioner applying for renewal of clinical privileges must submit the following information:
   
a. An application for clinical privileges as outlined in Section 8.02 of this Article. This includes submission of the electronic re-credentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.

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

   c. A statement of the Practitioner’s physical and mental health status as it relates to Practitioner’s ability to function within privileges. This must be confirmed by a physician, Nurse Practitioner, or Clinical Nurse Specialist acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the MEC.

   d. The number of completed CME units related to area and scope of clinical privileges, (consistent with minimum state licensure requirements) not previously submitted.

   e. A statement of the current status of all licenses, licenses previously held which have lapsed since last appointment, and certifications held. The status of all licenses and certifications must be validated. This applies to licenses held in multiple states for the same professional discipline or practice.

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

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

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

2. **Process**:
   
a. Recommendation for renewal of clinical privileges will be based on reappraisal by the Clinical Service Chief of application materials. The Clinical Service Chief and, if applicable, the Clinical Section Chief will complete an assessment that denotes a Provider’s current competence and performance activities during the past
renewal cycle. Clinical Service Chiefs are responsible for all initial and renewal service chief appointments in VetPro.

b. Completed renewal packets are submitted by the Clinical Service Chief to the PSB for review. The PSB shall make appropriate recommendations to the MEC, who subsequently makes recommendations directly to the Health Care System Director for final review and approval.

c. Any Medical Staff member may request a change in clinical privileges if the member believes such a change is warranted as a result of additional training, experience, or change in circumstances. The process is initiated by submitting a new completed privileging request form with supporting documentation to the Clinical Service Chief, who shall approve if appropriate. The request form is submitted to the PSB for review, approval, or denial. A period of proctoring with a member of the Medical Staff or with some other professional as determined by the Clinical Service Chief, PSB, or Chief of Staff may be necessary whenever clinical privileges are expanded. The PSB shall recommend approval of changes in clinical privileges to MEC who then further recommends to the Health Care System Director for final review and approval.

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

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

a. Current and previously held licenses in all states.

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

c. NPDB Continuous Query Registration.

d. FSMB query, if there was no break in service between recredentialing cycles.

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

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

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

i. Board certifications, if applicable.

j. Quality of care information.

4. Bylaws Receipt and Pledge: Prior to the renewal of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules. This attestation must be made in VHA’s electronic credentialing system before the provider can submit their application for appointment or privileges.
Section 8.04 Processing an Increase or Modification of Privileges

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

2. Primary source verification is conducted as required for credentialing, e.g. Provider attests to additional training.

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

4. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the MEC followed by the Director’s approval.

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

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

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

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

a. Recommendations for initial, renewal, or modification of privileges are based on a determination that applicant meets criteria for appointment and clinical privileges for the Service including requirements regarding education, training, experience, references and health status. Consideration will also be given to the six core competencies in making recommendations for appointment. The same six core competencies are considered for both initial appointment and reappointment. The core competencies are:
i) Medical/Clinical knowledge (education competency).
ii) Interpersonal and Communication skills (documentation, patient satisfaction).
iii) Professionalism (personal qualities).
iv) Patient Care (clinical competency).

v) Practice-based Learning & Improvement (research and development).
vi) System-based Practice (access to care).

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

3. The MEC recommends granting clinical privileges to the Director based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. The Chief of Staff, as chair of the MEC, can make the initial review and recommend appointment.

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

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

Section 8.06 Exceptions

1. Temporary Privileges for Urgent Patient Care Needs: Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of an initial appointment for a limited period of time not to exceed 60 calendar days or 45 business days, whichever is longer, by the Director or Acting Director on the recommendation of the Chief of Staff.

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

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

   ii) Two references from peers who are knowledgeable of and confirm the Practitioner’s competence and who have reason to know the individual’s professional qualifications.

   iii) Current comparable clinical privileges at another institution.

   iv) Response from NPDB Continuous Query Registration with no match.
v) Response from FSMB with no reports.

vi) No current or previously successful challenges to licensure.

vii) No history of involuntary termination of Medical Staff membership at another organization.

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

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

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

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

3. Disaster Privileges: Described in the SFVAHCS’s Emergency Operations Plan (EOP) and in the MCM No. 11-108 “Credentialing Practitioners in the Event of Disaster”. In the event of the activation of the Hospital Incident Command System (HICS), Disaster Privileges may be approved by the Medical Center Director, Chair of MEC or their designee(s), if it is determined that it is not possible to handle the influx of patients with the existing Practitioners.

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

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

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

5. Deployment and Activation Privilege Status: In those instances where a Practitioner is called to active duty, the Practitioner’s privileges are documented for informational purposes in the Medical Executive Committee minutes as being placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment.
a. Facility staff request that a Practitioner returning from active duty communicate with the Facility staff as soon as possible upon returning to the area.

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

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

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

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

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

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

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

i) Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen.

ii) Registration with the NPDB Continuous Query with no match.

iii) A response from the FSMB with no match.

iv) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.
v) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

ARTICLE IX. ALLIED HEALTH PRACTITIONERS

Allied Health Practitioners (AHPs) are not physicians or dentists and are not Advanced Practice Professionals. AHPs are dependently credentialed and practice under a functional statement with appropriate supervision by Medical Staff Members. AHPs are not members of the Medical Staff and do not have Medical Staff voting rights. AHPs include:

1. Dietitians
2. Audiologists and Speech Pathologists
3. Occupational and Physical Therapists
4. Pharmacists (not clinical)
5. Social Workers
6. Registered Dental Hygienists

Section 9.01 Qualifications

AHPs are subject to the qualification requirements contained in VHA and/or Office of Personnel Management regulations and specific state licensure requirements. Their individual responsibilities are described under functional statements. However, the PSB and the MEC review and approve Master Scopes of practice on an annual basis for AHPs with scopes. The Clinical Services that employ AHPs utilize the approved Master Scopes of Practice in conjunction with Dependent Credentialing for individual AHPs. Final approval of Master Scopes of Practice resides with the Medical Center Director. In accordance with Title 38 guidelines, qualifications of individual AHPs are reviewed by the PSB of their respective Service for those who have scopes.

1. Appropriate training, experience, and current continuing competence.

2. The ability to:
   a. Exercise judgment within their areas of competence, provided that a member of the Medical Staff has the ultimate responsibility for patient care.
   b. Participate directly in the management of patients under the supervision or direction of a physician member of the Medical Staff.
   c. Make entries in patients' medical records within the limits established by the Medical Staff.
Section 9.02 Credentialing Allied Health Professionals

1. The Pharmacy PSB will review and approve all credentials, competence, and performance improvement data for non-clinical Pharmacists.

2. Master Scopes of practice for AHPs will be reviewed annually by the PSB session of the MEC, with the exception of non-clinical Pharmacists and registered Dental Hygienists, who have functional statements and are not on scopes of practice.

3. Individual AHPs will have their credentials reviewed by HRMS and the PSB of the AHP’s Service in accordance with Title 38.

Section 9.03 Dependent Credentialing of Health Care Practitioners

All health care professionals at the SFVAHCS who claim licensure, certification, or registration, as applicable to the position (this applies to all who are appointed or utilized on a full-time, part-time, intermittent, consultant, without compensation, on-station fee-basis, on-station contract, or on-station sharing agreement basis), and who are not currently credentialed in accordance with VHA Handbook 1100.19, must to be credentialed in accordance with Directive 2006-067.

ARTICLE X. INVESTIGATION, SUMMARY SUSPENSION AND PRIVILEGING ACTION

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

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

   a. Material that is obtained as part of a protected performance improvement activity (i.e., 38 U.S.C. 5705) may not be used to support an administrative action although performance improvement data, such as that obtained as a result of an Ongoing Professional Practice Evaluation (OPPE), may trigger a more comprehensive review of the Practitioner’s work.
b. Quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705. Therefore, if such information is necessary in order to conduct a review of the alleged professional deficiencies and any action resulting from the review, it must be developed through mechanisms independent of the performance improvement program, such as a fact-finding, a comprehensive focused clinical care review, an administrative investigation, etc.

3. **Summary Suspension of Privileges:** The Director has the authority, whenever immediate action must be taken in the best interest of patient care due to the potential of imminent danger to the health and well-being of an individual, including the Practitioner, to summarily suspend all or a portion of a Practitioner’s delineated clinical privileges. Such suspension shall become effective immediately upon imposition by the Medical Center Director. The typical process to be followed in order to summarily suspend a Practitioner’s privileges is as follows (for information about the Automatic Suspension of Privileges, see paragraph 6 below):

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

   b. The Medical Center Director will approve the request, if appropriate, and the Practitioner will be issued a notification letter that all or part of the Practitioner’s clinical privileges are suspended and include the general reason that the action being taken. This notice will also include information in regards to the requirement to report the individual to the National Practitioner Data Bank (NPDB) if the Practitioner should retire or resign prior to the conclusion of the clinical review and any action resulting from those findings being imposed. (NOTE: Management’s decision to take a Practitioner out of patient care or place a Practitioner in an authorized leave status due to patient care concerns will result in a summary suspension of clinical privileges being imposed as the underlying reason for such action is due to concerns about the imminent danger to the health or well-being of an individual, and a summary suspension of clinical privileges letter must be issued to the Practitioner immediately.)

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

   d. The written notification of summary suspension of clinical privileges affords the Practitioner the opportunity to submit, within 14 calendar days from receipt of the summary suspension notification letter, a written response to the concerns identified within the letter.
e. Upon the receipt of the Practitioner’s written response, the Medical Center Director will determine whether or not the summary suspension of privileges should continue to be imposed pending the outcome of the comprehensive clinical review and any further action imposed as a result of the review. If the decision is made to continue the summary suspension of privileges, the Practitioner’s response to the identified issues will be shared with the individual(s) conducting the review of the clinical concerns.

4. Administrative Denial of Privileges Pending the Outcome of an Investigation
   a. If a Practitioner’s privileges are due to expire during a Summary Suspension, they must still be asked to submit information required for recredentialing and request all privileges that were held prior to the Summary Suspension. Failure to request all privileges previously held will be considered a voluntary relinquishment of privileges during an investigation and may be reportable to the NPDB if the Practitioner is a physician or dentist.
   b. The service chief and Executive Committee of the Medical Staff may recommend an Administrative Denial of Privileges Pending the Outcome of an Investigation rather than recommending the granting or denial of privileges before all relevant information to make such a determination is available.
   c. The Practitioner will be notified in writing of the decision to administratively deny the privileges pending outcome of the investigation. The notification will also inform the provider that they remain under investigation and that this action is not reportable to NPDB as it is an administrative action and not “for cause”.
   d. The Practitioner’s privileges will lapse on the expiration date (cannot be extended for any reason) and the Practitioner will not hold privileges at this facility until the Investigation has concluded and there is a decision based upon the outcome as to whether the requested privileges will be granted or denied.
   e. An administrative denial of privileges may be taken on one or more privileges depending upon the circumstances. If the summary suspension was not for all privileges, the recommendation may be to grant select privileges and administratively deny those that under investigation.
   f. If the requested privileges are subsequently denied after the Investigation has concluded, subsequent appointment and Human Resource actions will be considered accordingly.

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

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

c. If the Practitioner is not summarily suspended as indicated in paragraph 3 of this Part, the Practitioner will be issued a letter notifying the Practitioner that if he/she resigns or retires while the review is being conducted, the Practitioner may be reported to the National Practitioner Data Bank (NPDB).

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

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

f. The reviewer(s) may review any documentation needed to fully assess the issues (except for those exempt in paragraph 2 above) and/or interview witnesses, including the Practitioner, at their discretion. The reviewer(s) should be asked if the provider met the standard of care (yes or no) and if not, why the standard was not met.

g. The report of the comprehensive focused clinical care review will be made to the MEC within 30 days after the reviewers have completed the investigation. The MEC will assess the results and make a recommendation to the Medical Center Director regarding the appropriate action to be taken. The MEC has the discretion to meet with the Practitioner within 10 calendar days after receipt of the evidence to ask him/her questions about the findings before reaching a conclusion regarding their recommendations. The MEC is not required to meet with the Practitioner, and if the Practitioner fails to meet with the MEC within a reasonable period of time, which is typically 14 days calendar days after the meeting is requested, the MEC must submit its recommendation for action without the Practitioner’s input. This proceeding does not constitute a hearing, and there is no entitlement to any procedural rules set forth in Article XII of these Bylaws or any other VA regulations. The MEC is not required to share
the report or any supporting documentation in advance of the proceeding or during the proceeding with the Practitioner. A record of such proceedings will be made and included with the reviewers’ findings, conclusions and recommendations that are submitted to the Director.

6. Recommendations Following the Review:

a. The MEC can make the following recommendations to the Director based on the evidence gathered before, during and after the review:
   i) No action;
   ii) Initiation of a Focus Professional Practice Evaluation (FPPE) for cause;
   iii) Revocation of privileges; or
   iv) Reduction in privileges.

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

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

d. FPPE for Cause:
   i) If the recommendation is for an FPPE for Cause to be initiated, privileges will be reinstated upon the creation and issuance of the FPPE for Cause. The FPPE for Cause will provide appropriate notification to the Practitioner of the areas of weakness and develop a plan under which the Practitioner can improve in order to successfully complete the FPPE for Cause and demonstrate the requisite skill and knowledge in those areas of clinical issues identified as a concern. (NOTE: An FPPE for Cause will normally be for a minimum of 60-calendary days. In general, extension of the FPPE for Cause is discouraged).

   ii) Upon completion of the FPPE for Cause, results will be reported back to the MEC.

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

e. Revocation of Privileges:
i) If the MEC recommends that the Practitioner’s privileges be revoked, or if a Practitioner fails an FPPE for Cause and the MEC subsequently recommends the revocation of privileges, the Chief of Staff will assess the evidence and coordinate the separation of the Practitioner with Human Resources Management Service, unless management offers the practitioner a position at the facility that does not require the Practitioner to have clinical privileges.

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

iii) If the Practitioner is appointed under the provisions of 38 U.S.C 7405(a)(1), (Temporary full-time appointments, part-time appointments, and without-compensation appointments) the Medical Center Director must determine if the Practitioner’s services are still needed given the reduction in privileges.

a) If it is determined that the Practitioner’s services are still needed, management will follow the procedures for modifying a Practitioner’s privileges.

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

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

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

7. Automatic Suspension of Privileges:

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

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

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

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

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

v) The Practitioner being on leave for an extended period of time such as chronic illness.

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

c. The Medical Center Director may initiate an appropriate review of the concern(s) or issue(s) resulting in the automatic suspension to include recommendations for appropriate administrative action.
If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in 1 calendar year, a thorough assessment of the need for the Practitioner’s services must be performed, documented in writing, and appropriate action taken.

8. **Actions Not Constituting Corrective Action:** The comprehensive clinical care reviewers responsible for conducting reviews are not deemed to have proposed an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a hearing under Article XII or a Disciplinary Appeals Board (DAB) will not have arisen in any of the following circumstances:

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

   b. The conduct of an investigation into a matter;

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

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

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

   f. Corrective counseling;

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

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

---

**ARTICLE XI. FAIR HEARING AND APPELLATE REVIEW**

Fair Hearing and Appellate Review are also described in Appendix A.

1. **Reduction of Privileges:**

   a. Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:

      i) A description of the reason(s) for the change
ii) A statement of the Practitioner’s right to be represented by counsel or a representative of the individual’s choice, throughout the proceedings.

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

c. Information will be forwarded to the Director for decision. The Director will make a decision on the basis of the record. If the Practitioner disagrees with the Director’s decision, a hearing may be requested. The Practitioner must submit the request for a hearing within five – business days after receipt of decision of the Director. A proposed action taken to reduce a Practitioner’s privileges will be made in accordance with VHA Handbook 1100.19. In instances where reduction of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 38 United States Code (Appointment in Veterans Health Administration), the proposed reduction of privileges will be combined with a major adverse action (e.g. suspension, reduction in basic pay, reduction in grade, transfer, etc.) in accordance with Section 7461 7464 of Title 38, United States Code (Adverse actions: section 740 and VA Handbook 5021 Employee/Management Relations. NOTE: A major adverse action may not be proposed against a 38 U.S.C. Section 7403 or Section 7405 (except nurses) employee, or a contractor.

d. Convening a Panel:

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

ii) In the case of a reduction in clinical privileges that does not constitute a major adverse action or is not combined with a major adverse action in accordance with VA Handbook 5021, the Director must appoint a review panel of three unbiased professionals, within five business days after receipt of the Practitioner’s request for hearing. These professionals will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record.

e. Hearing Process: The hearing will proceed as follows:
i) The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 business days and not more than 30 business days from the date of notification letter.

ii) The Practitioner has the right to:
   (1) Be present throughout the evidentiary proceedings.
   (2) Be represented by an attorney or other representative of the Practitioner's choice (provided that this representative does not have a conflict of interest) during the hearing.
   (3) Cross-examine witnesses during the hearing.
   (4) Purchase a copy of the transcripts or a recording of the hearing.

iii) During the hearing, the chair shall do the following:
   (1) Act to ensure that all participants in the hearing have reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
   (2) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no longer than a total of 15 hours.
   (3) Maintain decorum throughout the hearing.
   (4) Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
   (5) Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel when formulating its recommendations.
   (6) Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.
   (7) The Chair shall seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

iv) In cases involving reduction of privileges, a determination must be made as to whether disciplinary action should be initiated.

f. Hearing Findings: The panel will complete its review and submit its report within 15 business days from the date of the close of the hearing. The panel may request in writing that the Director grant additional time due to extraordinary circumstances or cause. The panel’s report, including findings and
recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel’s recommendations.

g. Director Decision: The Director will issue a written decision within 10 business days of the day of receipt of the panel’s report. If the Practitioner’s privileges are reduced, the written decision will indicate the reason(s) for the change.

h. Practitioner Appeal: The Practitioner may submit a written appeal to the VISN 21 Director within five business days of receipt of the Director’s decision.

i) The VISN 21 Director will provide a written decision based on the record within 20 business days after receipt of the Practitioner’s appeal. The decision of the VISN 21 Director is not subject to further appeal.

ii) A Practitioner who does not request a review panel hearing but who disagrees with the Director’s decision may submit a written appeal to the appropriate VISN 21 Director within five business days after receipt of the Director’s decision.

iii) The review panel hearing defined in paragraph d and e will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted based on the record.

i. Voluntary Surrender: If a Practitioner surrenders or voluntarily accepts a restriction of his/her clinical privileges, or resigns or retires from his/her Medical Staff position with the Department of Veterans Affairs while the Practitioner’s professional competence or professional conduct is under investigation to avoid investigation, if greater than 30 days such action is reported without further review or due process to the NPDB and the appropriate state licensing boards.

2. Revocation of Privileges:

a. Revocation of privileges refers to the permanent loss of all clinical privileges.

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

i) In instances where revocation of privileges is proposed for permanent Title 38 employees appointed under Section 7401(1) of Title 39 United States Code, the proposed revocation will be combined with action to discharge the employee under Section 7461-7464 of Title 38 USC and VA Handbook 5021 Employee/Management Relations.

ii) For probationary employees appointed under 38 USC 7401(1) and part-time temporary registered nurses appointed under 38 USC 7405, the Professional Standard Board (PSB) will convene in accordance with the procedures outlined in VA Handbook 5021, Employee/Management Relations. If separation is recommended and the recommendation from the PSB is based in whole, or in part, for reasons of substandard care, professional incompetence, or professional misconduct, the Director, or designee, may separate the Practitioner as prescribed in VA Handbook 5021. Separation constitutes an automatic revocation of clinical privileges, which is reportable.
to the NPDB, if the Practitioner is a physician, dentist, nurse practitioner, or clinical nurse specialist, but only after being afforded due process. All practitioners, whether reportable to the NPDB or not, are entitled to due process.

iii) In instances where the Practitioner is appointed through a contract or other “at will” appointment, including but not limited to part-time (excluding part-time temporary registered nurses who are covered under the procedures in para 2(b)(ii), fee basis, without compensation, or intermittent appointment, separation may occur immediately, but separation constitutes an automatic revocation of clinical privileges and is reportable to the NPDB if the Practitioner is a physician, dentist, nurse practitioner, or clinical nurse specialist, and the revocation is for substandard care, professional incompetence, or professional misconduct. A report to the NPDB may not be filed until all due process has been exhausted.

c. Revocation procedures will be conducted in a timely fashion. Revocation of clinical privileges may not occur unless the Practitioner is also discharged, separated during probation, or the appointment is terminated. However, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the Practitioner is a Physician, Dentist, Nurse Practitioner, or Clinical Nurse Specialist and if the revocation of privileges and subsequent reassignment constitutes a major adverse action due to reduction in grade or basic pay for reasons of substandard care, professional incompetence, or professional misconduct. For example, a Surgeon’s privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by the MEC for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article XII of these Bylaws.

d. All full-time Title 38 employees are covered under the Disciplinary Appeals Board. All Title 5 Advanced Practice Professionals are covered under the Merit System Protection Board.

3. Reporting to the National Practitioner Data Bank¹:

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

b. When a claim is settled or a judgment is made against the Government (and a payment made), a VA review is conducted to determine if the involved Practitioners should be reported to the NPDB. The review must determine that

¹ Reference VHA Handbook 1100.17.
there was substandard care, professional incompetence, or professional misconduct and if so, is attributable to a licensed Practitioner in order to meet reporting requirements.

c. Practitioners are also identified and notified at the time a tort claim is filed so that they may assist regional and general counsel in defending the case and in decisions concerning denial or settlement.

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

e. VA only reports privileging actions that adversely affect the clinical privileges of physicians, dentists, nurse practitioners, or clinical nurse specialists, after a professional review action or if the Practitioner surrenders clinical privileges while under investigation. The professional review action is the due process (e.g. fair hearing and appeal process) afforded the Practitioner for a reduction or revocation of clinical privileges. The reference for this is 38 CFR part 46.4. The notice of summary suspension to the Practitioner must include a notice that if a final action is taken, based on professional competence or professional conduct, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. After the final action, the reduction or revocation as well as the summary suspension if greater than 30 days will be reported.

f. Disclosure of information regarding malpractice payments determined by peer review to be related to professional incompetence or professional misconduct on the part of a Practitioner will follow provisions of the VHA Handbook 1100.17 entitled "National Practitioner Data Bank Reports" and MCM No. 11-35, "Procedures and Responsibilities for Reporting Malpractice Settlements and Adverse Clinical Privileging Actions to the National Practitioner Data Bank.”

4. Reporting to State Licensing Boards: VA has a responsibility to report to state licensing boards appointed or suspended members of the Medical Staff whose behavior or clinical practice so substantially fails or failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. Disclosure of information to State licensing boards regarding Practitioners separated from VA service will be completed under the provision of M-2, Part I, Chapter 34.

5. Management Authority: Nothing in these procedures restricts the authority of management to detail or reassign, on a temporary basis, an employee to non-patient care areas or activities, thus suspending privileges, during the pendency of any proposed reduction of privileges or discharge, separation, or termination proceedings. Further, the Director, on the recommendation of the Chief of Staff, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns. Individuals appointed under authority of 38 USC7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.
6. **Termination of Appointment:** Termination of Medical Staff appointments will be accomplished in conjunction with, and follow procedures for, terminating appointments of Practitioners set forth in VA Handbook 5021, Part II, Federal and VA acquisition regulations and Title 5 authorities including VA Handbook 5021, Part I. The notification will briefly state the basis for the action.

**ARTICLE XII. RULES AND REGULATIONS**

The Rules are included here as may be necessary to implement more specifically the general principles of conduct found in these Bylaws and to identify the level of clinical practice that is required of each member of the Medical Staff and of all others with delineated clinical privileges or practicing under a Scope of Practice. Rules may be adopted, amended, repealed, or added by a majority vote of the members of the MEC present and voting at any meeting of that Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. Medical Staff Rules must be approved by the Director.

**ARTICLE XIII. AMENDMENTS**

1. The Bylaws and Rules are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from MEC. Changes to the Bylaws can be amended, adopted, and voted on by 25% of Medical Staff members. Then changes to the Bylaws and Rules are approved by the Director.

2. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.

3. In cases of a documented need for an urgent amendment to rules and regulations, the MEC may provisionally adopt and the Director may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified of the provisional amendment by the MEC. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Director for approval.

4. In cases of conflict between the Medical Staff and MEC on issues including, but not limited to proposals to adopt a rule, regulation, policy, or an amendment any ten members of the Medical Staff may request a meeting with the MEC. The MEC shall meet with those members of the Medical Staff. Prior to the meeting, a neutral panel chosen by the Director will summarize the issues for discussion. During the
meeting, the MEC and Medical Staff will make a good faith effort to resolve the conflict. In the event the conflict cannot be resolved, the Director will have the authority to make a final determination.

5. All changes to the Bylaws and Rules, except as described in part 3 above, require action by both the Organized Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.

6. Changes are effective when approved by the Director.

**ARTICLE XIV. ADOPTION**

These Bylaws and Rules shall be adopted upon recommendation of the Medical Staff at regular or special meetings of the Medical Staff, and via a Medical Staff electronic and/or mail notification process. They shall replace any previous Bylaws and Rules and shall become effective when approved by the Director.

**RECOMMENDED**

R. N. Shah
Interim Chief of Staff

12-4-2017

**APPROVED**

Bonnie S. Graham, MBA
Health Care System Director

12-6-17
MEDICAL STAFF RULES

1. GENERAL
   A. The Rules relate to roles and/or responsibilities of members of the Medical Staff with clinical privileges in the care of inpatients, emergency care patients, and ambulatory care patients as a whole or to specific groups as designated.
   B. Rules of Departments or Services will not conflict with each other, rules and policies of the Medical Staff, or with requirements of the Governing Body.
   C. Members of the Medical Staff are responsible for carrying out these Rules to assure compliance with VHA directives and the standards of the Joint Commission and other accrediting bodies.
   D. The Medical Staff as a whole shall hold meetings at least annually.
   E. The Medical Executive Committee serves as the executive committee of the Medical Staff and between the annual meetings, acts on their behalf. The Committee is responsible for continually reviewing the quality of the clinical care carried out at SFVAHCS.
   F. Each of the Clinical Services shall conduct meetings at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of patient care and treatment. Minutes must reflect discussion by Medical Staff and responsible parties of patient care issues, with resultant significant conclusions, recommendations, action taken, and evaluation of follow-up actions.
   G. Information used in quality improvement as referenced in Article XI, cannot be used when making adverse privileging decisions.
   H. Medical Center Memoranda are considered an extension of the Rules. They are available to all staff through SFVAHCS Intranet, Employee Resources, and to prospective staff upon request.

2. PATIENT RIGHTS
   A. Patients’ Rights and Responsibilities: Respect for patients’ rights shall be a basic tenet of SFVAHCS. All programs will support and protect the fundamental human, civil, constitutional, and statutory rights of each individual patient as outlined in MCM No. 11-49, “Patient and Nursing Home Resident Rights.” Patients’ Rights shall include the following:
      i) Reasonable response to requests and need for service within capacity, mission, laws, and regulations.
      ii) Considerate and respectful care that fosters a sense of dignity, autonomy, and civil rights.
      iii) Collaboration with the physician in matters regarding personal health care.
      iv) Pain management including screening, assessment, treatment and education, as outlined in MCM No. 11-50, “Management of Pain.”
v) Development, implementation, articulation, and application of ethical principles in accordance with MCM No. 00-26, “Organizational Code of Ethics.”

vi) Participation of patient and/or patient's representative in consideration of ethical decisions regarding care.

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

viii) Formulation of advance directives and appointment of surrogate to make health care decisions in accordance with MCM No. 11-73, “Advance Care Planning.”

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

x) Recognition of the patient’s right to accept or refuse any treatment or procedure offered, as described in MCM No. 11-37, “Informed Consent”

xi) Access to information about patients’ rights and handling of patient complaints.

xii) Access to information regarding any human experimentation or research/education projects affecting patient care.

xiii) Recognition of the patient’s right to agree to participate in research or to elect not to do so.

xiv) Personal privacy and confidentiality of information.

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

xvi) Authority of Clinical Service Chiefs to approve/authorize necessary surgery, invasive procedure, or other therapy for a patient who is incompetent to provide informed consent, when no authorized surrogate or next of kin is available.

xvii) Foregoing or withdrawing life-sustaining treatment including resuscitation in accordance with MCM No. 11-45, “Do Not Resuscitate Procedures.”

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

xix) Recognition of the patient’s right to donate organs/tissue in accordance with MCM No. 11-59, “Organ/Tissue Donation and Notification of Organ Procurement Organizations.”

B. Human Research: Patients have the right to agree to participate in research or to elect not to do so. This decision in no way affects the patient’s eligibility for
ongoing care at SFVAHCS. All activities related to human subject research, regardless of funding source, will be guided by the ethical principles of respect for persons, beneficence, and justice as outlined in the Belmont Report. All personnel, including members of the Medical Staff, conducting research at this facility are bound by legal and ethical requirements to obtain and maintain appropriate approvals for their work, protect the confidentiality of all information that can be identified with a person, report any adverse events or ethical breaches, participate in educational programs, and cooperate in for-cause and not-for-cause investigations. The SFVAHCS will adhere to the guidelines of the Committee on Human Research, UCSF and MCM No. 11-19, “Human Research Protection Program (HRRP).”

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

i) Competent patients have the right to consent to and equally to decline any treatment including the provision of life-sustaining treatment. Accordingly, life-sustaining treatment will not be provided to competent patients who decline it. Similarly, life-sustaining treatment will be provided, consistent with prevailing medical practice, when the competent patient consents or in emergent situations where informed consent may be implied. When the competent patient withdraws consent to any treatment to which the patient has previously consented, including the provision of life-sustaining treatment, such treatment will be withdrawn. He/she will be informed of the medical consequences of such decisions.

ii) Medical decisions regarding the patient’s diagnosis, prognosis, and treatment options to be presented to the patient, shall be made by the Attending Physician in consultation with, as appropriate, other members of the treatment team 38 U.S.C sections 7331.

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

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

v) Advance Directives: The Medical Staff will encourage the rights of each patient to execute an Advance Directive if he/she so chooses, in accordance with MCM No. 11-73, “Advance Care Planning and Management of Advance Directives.” The patient’s right to direct the course of medical care is not extinguished by the loss of decision making capacity. To respect this right when the patient lacks decision-making capacity, VHA recognizes the right of an adult person to make an Advance Directive in writing, concerning all
treatment, including life-sustaining treatment. Any competent patient may execute a declaration requesting some or all life-sustaining treatments be withheld or withdrawn. The desires of any VA patient, as expressed at the time the Advance Directive is to be implemented, shall supersede those previously expressed in an advance directive. In addition, an Advance Directive may be revoked by a declarant at any time.

vi) **Substituted Judgments:** The rights of patients to direct the course of medical treatment are not extinguished by the lack of decision-making capacity or by the fact that an Advance Directive has not been previously executed. VHA is directed by statute to ensure, to the maximum extent practicable, that medical care is provided only with the full and informed consent of the patient or, in appropriate cases, the patient's surrogate decision maker. Accordingly, "Substituted Consent" shall be secured from an incompetent patient's surrogate decision maker prior to the initiation of treatment, except in emergent situations, in accordance with MCM No. 11-37, "Informed Consent." The person making decisions for a terminally ill patient who lacks decision-making capacity should act as that patient's "surrogate" for purposes of consenting to, or declining, life-sustaining treatment. Life-sustaining treatment will not be withheld or withdrawn under this paragraph unless the attending physician is satisfied that the decision of the surrogate decision maker is based on reliable indicators of the direction the patient would personally give were the patient able to do so. Such indicators might include, but are not limited to, the following:

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

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

(c) Deductions drawn from the patient's religious, moral, ethical, or philosophical beliefs, from the patient's value system, or from the patient's consistent pattern of decision making with respect to prior medical care. In cases where such indicators are lacking, conflicting, or are insufficient (due, for example, to remoteness or non-specificity) to form a reliable basis for decision making based on the patient's own subjective wishes, life-sustaining treatment will be withheld or withdrawn only when the surrogate decision maker and the attending physician agree that the withholding or withdrawal of life-sustaining treatment would be in the patient's best interests. In cases where the Attending Physician believes in good faith that the decision of the surrogate decision maker is equivocal, does not reflect the patient's own desires or best interests, or is based, even in part, on factors (such as self-interest) other than the advancement of the patient's own desires or best interests, the Attending Physician may decline to implement the decision to withhold or withdraw life-sustaining treatment. Such cases will be referred to the Integrated Ethics Council or Chief of Staff.
3. RESPONSIBILITY FOR CARE

A. Conduct of Care

i) Management of the patient's general medical condition is the responsibility of a qualified member of the Medical Staff.

(a) The Attending Physician is responsible for the preparation and completion of a complete medical record for each patient. This record shall include an updated problem list, identification data, chief complaints, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-ray and others, provisional diagnosis, medical and/or surgical treatment, operative report, pathologic findings, progress notes, doctor's discharge instructions sheet, including condition on discharge and final diagnosis, and final discharge summary.

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

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

(d) Progress notes will be written by the House Staff at least once daily on all acutely ill patients. Progress notes are written for all patients seen in ambulatory care settings by the Medical Staff, Advanced Practice Professionals, or residents.

(e) Evidence of required supervision of all care by the Attending Physician shall be documented in the medical record. The frequency of attending notes is dependent upon the severity of the illness of the patient. It is a cardinal principle that responsibility for the care of each patient lies with the Attending Physician to whom the patient is assigned and who the Attending Physician supervises all care rendered by residents.

(f) Upon determination that a Do Not Resuscitate (DNR) order is appropriate, the order must be written or, at minimum, countersigned by the Attending Physician in the patient's medical record. There must be documentation of the order and how the decision was reached (e.g., discussed with patient or family). At any time a DNR order is written, the patient's rights will be observed. Once the order has been entered, it is the responsibility of the Attending Physician to ensure that the order and its meaning are discussed with appropriate members of the Facility staff, particularly the nursing staff, so that all involved professionals understand the order and its implications. For more information, see MCM no. 11-45, “Do Not Resuscitate Procedures.”
Physicians have responsibility for ensuring that transfers to or from SFVAHCS or between units within SFVAHCS are handled appropriately such that continuity of care is maintained. Patients will not be transferred out when SFVAHCS has the means to provide adequate care. Patients who are medically stable for transport may be authorized for transfer only after authorization is given by the appropriate Provider as defined in SFVAHCS policy. All transfers in and out of the SFVAHCS will conform to JC standards, particularly those dealing with emergency and non-emergency transfers, with transfer provisions of the Emergency Medical Treatment Act (EMTALA) and its implementing regulations, and all provisions of Title 42 USC 1395. For more details, see MCM No. 136-31, "Standards for Medical Records," 11-85, "Interfacility Transfer Policy," 11-15, "Discharge Planning for Inpatients," 11-22, “Resident Supervision,” and 11-63, “Provider Hand-off Communication.”

ii) Under similar clinical circumstances, the same quality of patient care is provided, by all individuals with delineated clinical privileges.

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

B. Emergency/Urgent Services: Basic emergent/urgent medical care is provided to patients who present to the Emergency Department. Patients are evaluated, treated, hospitalized, or transferred to other facilities according to assessed medical needs.

C. Admissions: The responsibility for determining medical need for admission is delegated through the Chief of Staff or the Deputy Chief of Staff, and/or the Chiefs of the inpatient clinical services, to the admitting physician. Determination of legal eligibility for admission is the responsibility of the Chief of Business Service. For more details, see MCM No. 118-01, “Admission and Bed Control Policy.”

i) Medical Staff members with admitting privileges are limited to those who hold privileges in the following Services:

   (a) Medicine
   (b) Surgery (excluding Podiatrists)
   (c) Mental Health (excluding Clinical Psychologists)
   (d) Neurology and Rehabilitation
   (e) Dental
   (f) Anesthesiology (Critical Care)
   (g) Geriatrics, Extended and Palliative Care.
ii) General dentistry patients are admitted to the Oral and Maxillofacial Surgery bed service. H&P examinations are performed by a Staff Dentist as well as by an Oral and Maxillofacial Surgeon.

iii) On a case-by-case basis, NPs may request admitting privileges. Specifics of privileges being granted will be defined.

iv) All patients admitted to the hospital for Podiatric care will be admitted to a service with inpatient admitting privileges. For patients who are medically stable, the patient will be admitted to Orthopedic Surgery. The Podiatry service will provide care to these patients with oversight from the medical hospitalist. An Attending Physician from the hospitalist service will complete an admission note in addition to the documentation from the Podiatry service.

v) All physicians performing invasive procedures must be specifically privileged to perform the procedures as outlined in MCM No. 11-02, “Credentialing and Clinical Privileges.”

vi) The Director of the Intensive Care Unit (ICU) has the responsibility to prepare and enforce policies regarding criteria for admission to and discharge in the ICU.

D. Consultations:

i) **Consultation:** The Medical Staff, through its Clinical Service Chiefs, shall assure that appropriate consultations are requested. Consultation is urged for the following situations:

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

(b) When the patient is high risk for an operative procedure.

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

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

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

(f) When specifically requested by the patient or family.

ii) **Consultant:** A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. The status of the consultant is determined by the Medical Staff and the PSB on the basis of an individual's training, experience, and competence. Residents or fellows may act as consultants when approved by the Clinical Service Chief, but all consultation notes should document the involvement of the appropriate Medical Staff member on the consulting Service.
iii) **Essentials of a Consultation:** A satisfactory consultation includes an examination of the patient and the medical record and a written report in the medical record. Each consultation report should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient’s medical record, and shall be a part of the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation. For consultations for inpatients, there must be verbal communication with the referring Provider at the time of the initial consultation when appropriate, wherever a recommendation is made for significant change in patient management, and when there is formal sign-off.

iv) **Availability:** The Clinical Service Chiefs will make certain that members of their staff provide timely consultation as needed.

v) **Ethical Considerations:** Appropriate medical ethics should be followed in consultations. The findings and opinions of the consultant should be limited to the clinicians involved. Patients should not be advised or treated by the consultant without timely communication of consultation recommendations to the referring Providers. This does not apply to referrals for care but only to consultation opinions.

vi) **Psychiatric Consultations:** For all patients who attempt suicide or take a chemical overdose see MCM No. 11-95, “Management of Suicidal Patients” for guidance. If the patient refuses to see the consultant, this fact must be documented by the consultant in the medical record.

E. **Discharge Planning:** Discharge planning is an essential component of quality health care and promotes effective utilization of resources. Effective discharge planning begins at the time of admission or as early as feasible and is based upon multidisciplinary collaboration. The goal of discharge planning is to ensure continuity of care in the return of the patient to the community at his/her optimal level of physical and psychosocial functioning. For more details, see MCM No. 118-18, "Discharge Planning for Inpatients.” The Director of the ICU is responsible for ensuring that there are discharge policies for patients in the ICU. The Chief of Anesthesiology Service is responsible for ensuring there are discharge policies for the Post-Anesthesia Care Unit (PACU). Discharge plans, including patient/caregiver education, medications, treatment, follow-up, and patient agreement are documented in the medical record.

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

ii) Discharge planning is documented in the medical record.

iii) Criteria for discharge are determined by the Multidisciplinary Treatment Team.

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

F. **Discharge:**
i) Patients shall be discharged from the Facility only upon the written order of the physician. The discharge summary will be completed upon discharge for all patients being discharged and after deaths. Responsibility for the preparation of the discharge summary and for its content rest exclusively with the member of the medical staff having primary responsibility for the care of the patient. If not the author, the supervising practitioner must review the summary, make appropriate amendments, and indicate approval by co-signature. The completed (signed) summary must be available for viewing in CPRS within 2 business days of discharge from an inpatient setting and within 3 business days for CLC residents.

ii) In the event of patient’s death, there will be documentation to support the time, date and events leading to the death, by the physician and the nurse. Any patient leaving against medical advice (AMA) will have final progress note written by a physician indicating the reason for leaving and any special disposition arrangements.

iii) Patients from Ambulatory Surgery/Procedure Unit can be discharged based upon order of the LIP familiar with the patient or when the responsible Attending Physician is not available, based on relevant Medical Staff approved criteria. The LIP's name is recorded in the patient's medical record.

G. Telemedicine/Tele-radiology: Telemedicine and tele-radiology involve the use of electronic communication or other communication technologies to provide or support care at a distance.

H. Autopsy

i) It is the policy of this Medical Center to comply with applicable state, federal, and county laws and to give full cooperation to the Medical Examiner's Office when requested.

ii) The Primary or On-call Team is responsible for notifying a patient’s next-of-kin of his/her death. The Primary or On-call Team will discuss/request an autopsy on all patients (except Medical Examiner’s Cases) and document the discussion in the death note.

iii) Autopsy services are provided in the Facility by Anatomic Pathology. The availability of these services will be made known to the family of each decedent and the Medical Staff will attempt to secure authorization for autopsy examination in all deaths. Autopsies will be performed in accordance with the criteria in MCM No. 11-42, “Autopsies and Medical Examiner’s Cases.” Findings from autopsies should be used as a valuable source of clinical information in quality assessment and improvement activities.

iv) Pathology performed at another institution will be requested and if obtainable, will be utilized to assist with the final diagnosis.

v) In the interest of improving patient care and professional knowledge, every member of the Medical Staff, including the clinical House Staff, is
encouraged to actively seek permission via iMed Consent Form, for autopsies and to attend them whenever possible. Autopsies should be regarded as a means to discover significant ancillary findings, evaluate therapy, corroborate clinical diagnosis and assure high quality care, in addition to establishing the cause for death.

vi) There will be legal authorization by the next of kin for autopsy in all instances prior to the initiation of an autopsy, except as provided in 38 CFR 17-170. Whenever possible, the physician responsible for the care of the patient at the time of death will request permission from the next of kin to perform an autopsy.

vii) Autopsy examination may be performed for medical-legal reasons in cases of unexpected death upon compliance with 38 CFR 17.170, and VHA Handbook 1106.01 Autopsy Services (which includes Criteria for assignment to medical-legal status).

viii) Autopsy examinations are strongly encouraged in the following deaths:
   (a) Deaths in which an autopsy may help to explain unknown and unanticipated medical complications or deaths
   (b) Cases in which an autopsy may help allay concerns of the family and provide reassurance to them

ix) Anatomic Pathology will provide an autopsy report, including autopsy rates, to the MEC on a regular basis.

x) Autopsy Rates: Autopsies are encouraged as per VHA policy.

xi) Autopsy Criteria: VHA policy encourages autopsies be requested from next-of-kin for all deaths, with the request and response documented in the clinical record. Autopsy performance is tracked for quality management purposes as described in 38 CFR 17.170, VHA Handbook 1106.01, and MCM No. 11-42, “Autopsies and Medical Examiner’s Cases.” Those cases meeting criteria as Medical Examiner’s cases per policy will be referred to the appropriate County Medical Examiner’s Office in accordance with state statutes.

xii) Cases in which death was due to suspected negligence, incompetence, or criminal activity require referral to the Medical Examiner, as do all cases in which death may be due to occupational causes.

xiii) Standard precautions will be vigorously enforced for preventing transmission of infectious diseases during autopsy.

4. INVESTIGATIONAL DRUGS

Investigational drug protocols must be approved by the UCSF Committee on Human Research and the SFVAHCS Research and Development Committee before an investigational drug can be administered at SFVAHCS. All investigational drugs are to be supplied through the Pharmacy Service. Pharmacy Service will store, dispense and
maintain accountability for the investigational drugs. For more details, see MCM No. 119-08, "Investigational Drugs" and 11-19, "Human Research Protection Program."

5. PHYSICIANS' ORDERS

A. General Requirements: General Medical Center policies regarding physicians' orders are delineated in MCM No. 11-24, "Healthcare Provider Orders."

B. Medication Orders

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

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

iii) Duration of Orders:

(a) Schedule II controlled drugs will be written for periods not to exceed 30 days for in-patients and must be reentered by electronic entry into Clinical Patient Records System (CPRS) for each succeeding period of 30 days or less.

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

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

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

iv) Ambulatory Care Medication Orders:

(a) All prescriptions must be entered electronically.

(b) All prescription controlled substances will follow VHA Handbook 1108-1.

(c) Ninety days is the maximum duration for applicable outpatient prescriptions

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

v) Transfer of Patients: When a patient is transferred from one level of care to another level of care, orders must be written for the new level of care. Where a patient is transferred from one nursing unit to another but remains under the care of the same physician, the existing orders remain valid.
C. **Standardized Order Sets** (protocols): Standardized order sets are reviewed periodically by Section or Service Chief and modified as needed. All standardized order sets in the medical record shall be authenticated by a Medical Staff member and are to be signed for each usage by Medical Staff. All concerned personnel shall be notified of revisions to standardized order sets by the Section or Service Chief.

D. **Informed Consent:**
   
   i) Informed consent will be consistent with legal requirements and ethical standards, as described in MCM No. 11-37, “Informed Consent.”
   
   ii) For procedures or treatments that require Informed Consent, evidence of receipt of Informed Consent documented in the medical record is necessary before that procedure or treatment may occur.

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

F. **Special Treatment Procedures:**
   
   i) **Do Not Resuscitate and Withholding/Withdrawal of Life Sustaining Treatment:** The policy of the SFVAHCS is to provide the highest quality medical care to its patients. The presumptive standard of care requires full resuscitative measures if cardiac arrest occurs. The only conditions that justify withholding full resuscitative measures are: a written DNR order, or a licensed physician (who knows the patient and exercises sound medical judgment) giving an instruction not to institute resuscitation of a patient who has just experienced an arrest. For more details, see MCM No. 11-45, "Do Not Resuscitate Procedures."

   ii) **Do Not Resuscitate Overview:**
       
       (a) Responsibility for medical decisions regarding the patient’s diagnosis or prognosis is shared by the medical treatment team and shall be reached by consensus. If, in spite of clear communication and thorough discussion, there is serious disagreement among members of the treatment team staff regarding the appropriateness of a DNR order or procedures for its implementation, then an Integrated Ethics consultation must be obtained. The Chief of Staff is responsible for making final decisions with regard to this policy only if the disagreement cannot be resolved with the assistance of the Integrated Ethics consultation.

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

(c) In cases where the patient is comatose or otherwise incompetent, and the patient has not executed either a declaration under VHA Handbook 1004.02, Advance Health Care Planning, or a similar document under authority of State Law, a decision for entry of a DNR order shall be reached after consultation between the patient's representative and the physician.

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

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

iii) Sedation/Analgesia Policy: Any non-anesthesiologist LIP administering moderate or deep sedation and anesthesia must be qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally. To this end, it is the policy of SFVAHCS that Providers must be clinically privileged in order to administer moderate or deep sedation and anesthesia for diagnostic and therapeutic procedures. VHA Directive 2006-023, “Moderate Sedation by Non-Anesthesia Providers” and MCM No. 11-14, “Sedation and Anesthesia by Non-Anesthesiologists During Diagnostic and Therapeutic Procedures” mandates that all Providers must either be ACLS certified or have received equivalent training and pass a National VA sedation test at the time of initial application for moderate and deep sedation privileges and at the time of renewal of moderate and deep sedation privileges.

iv) Protective Security:

(a) Combative/Confused Patients: It is the responsibility of the police to respond to any situation where a patient or other individual on station is in imminent danger of harming himself or another person. This may also require immediate clinical evaluation by the medical team for further consultation. In such instances, the Code Green Team will be activated. For more details, see MCM No. 11-20, "Code Green Team."

(b) Restraint and Seclusion: Because of their inherent risks, seclusion, and restraint will be used only when there is no reasonable alternative. For details of restraint and seclusion requirements, see MCM No. 11-52A, “Medical Center Restraint and Seclusion Policy for Medical-Surgical Reasons” and 11-52B, “Medical Center Restraint and Seclusion Policy for Behavioral Health Reasons.”
(1) An order for restraint for medical-surgical reasons will be required. Orders will be limited to no more than 24 hours and will specify: date and time of the order and the length of time the patient may be restrained. If emergency restraint was initiated by Nursing, an order will be written by a physician within twelve hours.

(2) Orders for restraint or seclusion for behavioral health reasons will specify: date and time of the order, specification of seclusion or restraining device(s), and length of time the patient may be secluded or restrained, not to exceed four hours. An order will be written by a physician within one hour of initiation of restraint or seclusion.

(c) Emergency Commitment: (Inpatients who require a change of status from voluntary to involuntary admission): A patient who becomes disturbed and seeks to leave the Medical Center may be detained as an involuntary patient for 72 hours if he/she is considered, due to mental illness, to be (1) a danger to others, (2) a danger to him/herself, or (3) gravely disabled (a condition in which a person is unable to provide for basic needs for food, clothing, or shelter). For more details, see MCM No. 11-54, "Psychiatric Consultations and Emergencies."

6. INCIDENT REPORTING

All incidents where a beneficiary is involved that either have caused harm or have the potential of causing harm and/or where there is evidence that medical devices have caused or contributed to an incident in which a serious illness, injury, or death of a patient occurred must be reported promptly by the person witnessing/discovering the incident. For further details, see MCM No. 11-51, "Patient Safety Program."

7. ROLE OF ATTENDING STAFF

A. Supervision of Residents and Non-Physicians:
   i) Physician House Staff are assigned to SFVAHCS for the primary purpose of receiving education and training in their respective specialties.
   
   ii) Residents are supervised by members of the Medical Staff in carrying out their patient care responsibilities. It is the responsibility of VA staff physicians involved in the residency training programs to ensure that the educational quality of these programs is maintained at a high level and that the patient care delivered by House Staff incident to their education and training is appropriate in content and of consistently high quality. Supervision of House Staff is not limited to that provided by Attending Physicians. Other health professionals provide feedback to House Staff about patient assessment and care. In the event a House Staff’s order for patient care or assessment of a patient’s condition is questioned by another health professional, that professional is responsible for communicating the question to the House Staff’s attending and to his/her own supervisor as well
as the House Staff. For more details, see MCM No. 11-22, “Resident Supervision,” 11-24, “Health Care Provider Orders,” and 11-32, “Medical Students.”

iii) The ultimate responsibility for all patient care rests with the Attending Physician.

iv) Advanced Practice Professionals and certain Allied Health Practitioners are supervised by the Medical Staff and are monitored under a Scope of Practice statement.

B. Documentation of Supervision of Resident Physicians

   i) Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient’s care by the Attending Physician as described in Facility Policy Memoranda, Medical Staff Bylaws, these Rules, and VHA Handbook 1400.1 Resident Supervision.

   ii) Entries in the medical record made by medical residents, or Advanced Practice Professionals (e.g., PAs) that require countersigning by supervisory or attending Medical Staff members are covered by appropriate SFVAHCS policy and include:

      (a) Medical H&P examination

         (1) For residents, the Attending Physician must examine the patient and enter an independent note or make an addendum to the resident’s note.

      (b) Discharge Summary

      (c) Operative Reports

      (d) Medical orders that require co-signature:

         (1) DNR

         (2) Withdrawing or withholding life sustaining procedures

         (3) Certification of brain death

         (4) Research protocols

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

         (6) Progress notes

      (NOTE: Because medical orders in CPRS do not allow a second signature (co-signature), the Attending Physician must either write the order for (1) through (5) above; or in an urgent/emergency situation, the House Staff or Advance Practice Professional must obtain verbal concurrence from the attending, document in the progress notes the discussion and concurrence, and can write and sign the order. The
Attending Physician must then co-sign the progress note noting the discussion and concurrence within 24 hours.)

iii) Residents are allowed to order laboratory studies, radiology studies, pharmaceuticals, and therapeutic procedures as part of their assigned levels of responsibility. In addition, residents are allowed to certify and re-certify treatment plans as part of their assigned levels of responsibility. These activities are considered part of the normal course of patient care and require no additional documentation on the part of the supervising Practitioner over and above standard setting-specific documentation requirements (VHA Handbook 1400.1 page 6).

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

8. MEDICAL RECORDS

A. Definition, Ownership, Control:

i) Medical records are legal documents and are the property of the Medical Center; they are under the custody of Health Information Management Service (HIMS). MCM No. 136-31, “Standards for Medical Records” details the primary components and management procedures for the medical record.

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

iii) The health record needs to reflect honest and candid statements; derogatory or critical comments are to be avoided. Individual employee names are not to be included in health record documentation unless the purpose is to identify practitioners for continuing care.

iv) Requests to retract authenticated electronic notes or reports will be made directly to HIMS or designee and action taken is strictly controlled by agents of HIMS.

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

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

B. Basic Administrative Requirements:

i) Entries must be electronically entered when possible, which automatically dates, times, and authenticates the author.

ii) Final diagnosis and complications are recorded without use of abbreviations and symbols.

iii) A list of abbreviations that should not be used can be found in MCM No. 136-31, “Standards for Medical Records” and is available in CPRS and VistA. Those abbreviations are not acceptable for use either handwritten or in CPRS.

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

v) Release of information in medical records must follow policy requirements and standard operating procedures for the SFVAHCS in accordance with MCM No. 136-43, “Release of Information from Patient Records.”

vi) Access to medical records of all patients shall be afforded to Medical Staff members for bona fide study and research, consistent with preserving patient confidentiality and privacy. Specific confidentiality requirements are found in Title 38 USC 7332.

C. Content of Medical Records:

i) Complete and accurate medical records are indispensable for the proper care of patients and are the focal point of communication among SFVAHCS personnel.

ii) Medical records must be current and contain:

(a) Patient identification (name, address, DOB, next of kin)
(b) Medical history including history and details of present illness/injury
(c) Observations, including results of therapy
(d) Diagnostic and therapeutic orders
(e) Reports of procedures, tests, and results
(f) Progress notes
(g) Consultation reports
(h) Diagnostic impressions
(i) Conclusions at termination of evaluation/treatment
(j) Informed consent before procedures or treatments undertaken and if not obtainable, the reason, as stated in MCM No. 11-37, “Informed Consent.”
(k) Evidence of medication reconciliation in accordance with MCM No. 11-81, “Medication Reconciliation”

iii) All notes must include the appropriate Provider name, credentials, and official organizational title in the electronic signature block; and should include National Provider Identifier (NPI).

iv) For the medical record, an Attending Physician must have:
    (a) Written orders for all medications and other treatment. Written orders may be prepared by a resident, intern, or Advanced Practice Professional.
    (b) An Admission Note. The Admission Note may be prepared by a resident, intern, or Advanced Practice Professional. Resident documentation must follow procedures outlined in the VHA Handbook 1400.1, “Resident Supervision” and MCM No. 11-22, “Resident Supervision.”
    (c) For consultations, a consultation note, recorded in accordance with MCM No. 11-64, “Patient Assessment”
    (d) Ordered the minimum routine tests required by the clinical service. All tests and procedures performed on patients of the Medical Center shall be documented in the medical record.
    (e) Documented all orders for the medical care and treatment of their patients
    (f) Countersigned verbal orders within 72 hours of the verbal order

   i) Attending physicians may choose to correct a discharge summary or operative report. If the electronic report is not authenticated the corrections may be made directly to the report. If the report is authenticated, an addendum is required.

D. Inpatient Medical Records: In addition to the items listed in section C above, all inpatient records are due at the time of discharge and are considered delinquent after 7 calendar days, and must contain, at a minimum the following:

   i) An admitting diagnosis at the time of admission
   ii) A history and physical (H&P) examination

   (a) The H&P must be performed within 24 hours of admission, including for Community Living Center (CLC). If an H&P examination has been
performed within 30 days before admission, such as in the outpatient clinic, this will be sufficient provided there is an interval progress note reflecting any subsequent changes that may have occurred or documentation that there have been no substantive changes at the time of admission.

(b) A history must include chief complaint, history of present illnesses, adult illnesses, operations, injuries, medications, allergies, social history (including occupation and habits such as alcohol, tobacco, and drugs), family history, chief complaint, and review of systems.

(c) A complete physical examination must include (but is not limited to) general appearance, review of body systems, review of the results of pertinent studies which includes but not limited to, laboratory, radiology tests, and other applicable findings based on the patient assessed personal history. Significant medical impressions will be documented in the note. The note must be authenticated by the Provider at the earliest possible time, but always within 24 hours of being written in CPRS.

iii) Progress notes documented, signed, and co-signed within 24 hours.

iv) For expired patients, a death note must be written at the time of death and a discharge summary must be performed separately per MCM 136-31, “Standards for Medical Records.”

v) Notes of any changes or additions to the diagnosis at the time of discharge.

vi) A discharge plan (from any inpatient admission), including condition on discharge.

vii) The discharge summary needs to be prepared for all releases from VHA care on the day of discharge. 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.

viii) Completed within 7 calendar days of discharge.

E. Outpatient Medical Records: In addition to the items listed in section C above, all outpatient notes and encounters must be complete within 3 calendar days of the ambulatory care visit, will be considered overdue after 4 days and delinquent after 7 days, and must contain, at a minimum:

i) A progress note for each visit

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

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

iv) Immunization status, as appropriate

v) Allergies

vi) Referrals and communications to other Providers
vii) List of significant past and current diagnoses, conditions, procedures, and drug allergies

viii) A signature by the Attending Physician on final reports for all invasive procedures in accordance with MCM No. 11C-03, “Invasive Procedures in Ambulatory Care.”

F. Surgeries and Other Procedures:

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

ii) Preoperative Documentation:

(a) In all cases of elective and/or scheduled major surgery and/or diagnostic and therapeutic procedures, and if circumstances permit in cases of emergency surgery, the Attending Physician must evaluate the patient and enter a pre-operative (pre-procedural) note describing: the findings of the evaluation, diagnosis(es), treatment plan and/or choice of specific procedure to be performed; discussion with the patient and family of risks, benefits, potential complications; and alternatives to planned surgery and signed consent.

(b) Invasive procedures and surgeries involving local and/or moderate sedation require a focused H&P or Subjective/ Objective/ Assessment/ Plan (SOAP) note addressing pertinent positive/negative information, indications for the procedure, known risks related to the procedure, and a physical exam pertinent to the procedure. A formal consultation to the service for performing the procedure that includes all required content will serve as an H&P if done within 30 days, but must be updated the day of the procedure.

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

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

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

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

(1) Pre-operative diagnosis

(2) Post-operative diagnosis
(3) Technical procedures used

(4) Surgeons

(5) Findings

(6) Specimens removed

(7) Blood loss

(8) Complications

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

(1) Anesthesia

(2) Drains

(3) Tourniquet Time

(4) Plan

iv) Post-Operative Documentation: The operative report must be completed and signed in accordance with MCM 136-31, “Standards for Medical Records.” The body of the report needs to contain: indication for the procedure; operative findings; technical procedure used; specimens removed; post-operative diagnosis; names of the Attending Physician, primary surgeon, and assistants; and the presence and/or involvement of the Attending Physician.

v) Post-Anesthesia Care Unit Documentation:

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

(b) The record must document the name of the Attending Physician responsible for the patient’s release from the recovery room, or clearly document the discharge criteria used to determine release.

(c) For inpatients, there needs to be at least one documented post-anesthesia visit after leaving the PACU. The note needs to describe the presence or absence of anesthesia-related complications.

(d) For outpatients, Ambulatory Surgery personnel (i.e., a nurse) must call the patient after surgery, to assess any complications, including anesthetic complications, as appropriate.

G. Completion of Medical Records:
i) Notes and entries made in the medical record should always include the date and time they were made. Thus, the date of an entry reflecting a correction should be the date the correction was made, not the date the error was made, and appropriate cross-referencing should be placed in the record, when necessary, to explain the correction.

ii) A record will be considered incomplete if it does not contain an H&P, discharge summary, and an operative report, if appropriate, or if there is no authenticating signature on these documents.

iii) Attending Providers will be responsible for the completion of records of their patients, including records of residents under their supervision.

iv) It is the responsibility of the Clinical Service Chief to ensure that medical records are completed by members of his/her department according to the established guidelines and policies.

v) Repeated failure to complete admission notes, consultations, discharge summaries, or operative reports within the required timeframes may result in the administrative suspension of clinical privileges for the Attending Provider.

vi) The ambulatory care medical record will be considered incomplete if the patient’s problem list of known significant diagnoses, conditions and procedures, drug allergies, and medications has not been completed immediately following the ambulatory visit.

vii) When emergency, urgent, or immediate care is provided, the patient’s record must contain:
   (a) The time and means of arrival.
   (b) When a patient receiving emergency, urgent, or immediate care leaves against medical advice.
   (c) Treatment, testing, documentation of findings, and diagnosis at discharge.
   (d) The conclusions at termination of treatment, including final disposition, condition at discharge, and instructions for follow-up care.

9. INFECTION CONTROL

Hospital acquired infections (HAIs) are potential hazards to all persons having contact with a hospital. The goal of the Infection Control Program at SFVAHCS is to provide a safe environment for all patients, visitors, and employees, including rotating, temporary, volunteer, and WOC staff. The main elements of this program include adherence to the principles of hand hygiene, standard blood and body fluid precautions, surveillance, analysis of HAIs, prevention strategies, and staff education. It is the responsibility of all SFVAHCS personnel to comply with the SFVAHCS infection control policies and the VHA Hand Hygiene Directive. For further details, see MCM No. 111W-09, “Infection Control Program,” and the Medical Center Infection Control Manual (which can be found
in the Infection Control Intranet site). For specific guidance on reportable diseases, see MCM No. 111W-02, “Reportable Diseases.”

10. CONTINUING EDUCATION

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

11. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

The VHA recognizes its responsibility to assist impaired professionals and collaborate with available programs designed to intervene, monitor, refer to treatment, and advocate for physicians and dentists. For more information see MCM No. 11-68, “Management of the Impaired LIP.”

A. Where there is evidence that a physician, dentist, nurse practitioner, or clinical nurse specialist’s practice is impaired as a consequence of chemical dependence or mental or physical illness, the Chief of Staff’s office will be notified. Practitioners are allowed to self-refer to a program for assistance for psychiatric, emotional, or physical problems. Assistance in the self-referral may be obtained from their Service Chief or Chief of Staff.

B. In cases of known or suspected impairment due to mental illness or substance use, the Chief of Staff may request an assessment by the Medical Board of California or other appropriate state or local agency.

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

D. VA and Facility policies, responsibilities, and procedures of the Employee Assistance Program and the VA Drug-Free Workplace Program are applicable to the Medical Staff. All Medical Staff are eligible to participate in the Employee Assistance Program (see MCM No. 05-22, “Employee Assistance Program”).

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

F. The education of all LIPs and other hospital staff about the recognition of illness and impaired Providers shall be done at New Employee Orientation or through a combination of HRMS and Service Level education.

12. DISASTER
Medical Staff have an inherent obligation to care for the sick and injured following natural or man-made disasters. All staff members should review their Services’ role in the Medical Center Emergency Operations Plan, review their Service’s Emergency Response Plans, and be familiar with their responsibilities during disaster drills or actual disasters. Refer to Article VIII, Section 6, on Disaster Privileging for volunteer physicians.

13. PEER REVIEW
Details of the Peer Review Program are provided for in MCM No. 11-16, “Peer Review for Quality Improvement.” It specifies that:

A. All Medical Staff members shall participate in the facility protected peer review program established by VHA policy.
B. All Medical Staff members will complete any required training associated with the policy.

Adopted by the Medical Staff, VHA Medical Center, San Francisco, California, this 30th Day of November 2017.
RECOMMENDED

Rina N. Shah, MD
Interim Chief of Staff

12-4-2017
Date

APPROVED

Bonnie S. Graham, MBA
Health Care System Director

12-6-17
Date
<table>
<thead>
<tr>
<th>PROCESS</th>
<th>RESPONSIBILITY</th>
<th>TIME LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Specific QI Review</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Service to gather information on alleged</td>
<td>Service Chief</td>
<td>D</td>
</tr>
<tr>
<td>substandard care or other deficiencies</td>
<td>Chief of Staff</td>
<td></td>
</tr>
<tr>
<td>(Protected under 38 USC 5705).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Service Chief to write a memo to COS with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner QI data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. COS to review memo from Service Chief &amp;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recommend if applicable, a PSB Ad Hoc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ad Hoc PSB Management Review</strong></td>
<td>Ad Hoc PSB</td>
<td>D+10</td>
</tr>
<tr>
<td><strong>Summary Suspension (can occur anywhere in</strong></td>
<td>Medical Center Director</td>
<td></td>
</tr>
<tr>
<td>the process if patient safety issue)**</td>
<td>(representing the Governing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Body)</td>
<td></td>
</tr>
<tr>
<td>1. The Practitioner will receive notification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of privileging action.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The Governing Body (Director) will</td>
<td></td>
<td></td>
</tr>
<tr>
<td>implement (if applicable) a summary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>suspension.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Letter of summary suspension will be</td>
<td></td>
<td></td>
</tr>
<tr>
<td>delivered to the Practitioner with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>outline of the entire process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MEC Review of PSB Recommendations</strong></td>
<td>Medical Center Director/COS/QM</td>
<td>D+20</td>
</tr>
<tr>
<td>COS reviews with Service Chief and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>determines if they agree with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COS and Service Chief meet with Director and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>determine action by Director (letter to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner as to outcome)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROCESS</td>
<td>RESPONSIBILITY</td>
<td>TIME LINE</td>
</tr>
<tr>
<td>---------</td>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Provider response and PSB/MEC Ad Hoc recommendations forwarded to Director for decision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director provides final decision with input from COS and Service Chief.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Due Process &amp; Fair Hearing Procedures with Panel of Peers</strong></td>
<td>COS/QM</td>
<td></td>
</tr>
<tr>
<td>1. Practitioner has a right to representation, to purchase a transcript, review evidence and right to cross-examine.</td>
<td>D+43</td>
<td></td>
</tr>
<tr>
<td>2. Upon receipt of Ad Hoc MEC recommendations, Practitioner has a right to request from Governing Body a Hearing.</td>
<td>D+58</td>
<td></td>
</tr>
<tr>
<td>3. Governing Body to set-up review panel of 3 professionals, 2 of which should be from the impacted Service.</td>
<td>D+72</td>
<td></td>
</tr>
<tr>
<td>4. Chair, Hearing Panel to submit written report back to Governing Body.</td>
<td>D+78</td>
<td></td>
</tr>
<tr>
<td>5. The Governing Body will render a written decision after review of the Hearing Panel's final report.</td>
<td>D+83</td>
<td></td>
</tr>
<tr>
<td>6. The Governing Body will send a letter to the Practitioner and his/her service chief for final action.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VISN Director Appeal Process</strong></td>
<td>VISN 21 Director</td>
<td>D+87</td>
</tr>
<tr>
<td>1. Governing Body to send letter to Practitioner of reduction or revocation of privileges &amp; notification that he/she has 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROCESS</td>
<td>RESPONSIBILITY</td>
<td>TIME LINE</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>days to appeal in writing to Director, VISN 21.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce or Revoke Clinical Privileges</td>
<td>Governing Body</td>
<td></td>
</tr>
<tr>
<td>1. If the Governing Body reduces or revokes the</td>
<td>D+90</td>
<td></td>
</tr>
<tr>
<td>Practitioner’s clinical privileges, the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioner’s name is submitted to the NPDB.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report to State Licensing Board(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Practitioner Must be Reported to State Licensing Board(s) via VISN and Veterans Affairs Central Office (VACO).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>