MEDICAL STAFF BYLAWS

OF THE

VA TENNESSEE VALLEY HEALTHCARE SYSTEM

DEPARTMENT OF VETERANS AFFAIRS

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PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the Veterans Affairs Tennessee Valley Healthcare System (VATVHS), hereby organize itself for self-governance, and to function with reasonable freedom and confidence in conformity with the laws, regulations and policies governing the Veterans Health Administration (VHA) and the bylaws and rules hereinafter stated. These Bylaws are consistent with all laws and regulations governing Department of Veterans Affairs (VA), and they do not create rights or liabilities not otherwise provided for in laws or VHA regulations. Medical Staff Bylaws shall be consistent with VA policy. Policies created within VA TVHS shall not conflict with the Medical Staff Bylaws and Medical Staff Rules and Regulations, nor shall policies conflict with each other.

VATVHS is a tertiary integrated healthcare system comprised of two hospitals, the Alvin C. York Campus in Murfreesboro, TN, and the Nashville Campus in Nashville, TN, and community based outpatient clinics located in Tennessee and Kentucky.

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

The VATVHS is committed to improving the health of veterans through a comprehensive and high quality healthcare system that focuses on each veteran's special needs. The integrated system provides an environment that fosters healthcare, research and encourages learning. Our vision is to become the healthcare system of choice for veterans. The values of this medical center are the core of all endeavors in fulfilling our mission and provide a focus for the services we provide. Five core values serve as the cornerstone of our commitment to the veterans we serve: Trust, Respect, Commitment, Compassion, and Excellence.

The medical staff complies with the medical staff bylaws, rules and regulations and policies. The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances, and taking action in others. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

DEFINITIONS (in alphabetical order)

Veterans Affairs Tennessee Valley Healthcare System is abbreviated and identified as VATVHS.

Academic Partnership Council: The APC is established by formal memoranda of affiliation between VATVHS and medical and dental schools and approved by the Under Secretary for Health. They are composed of Deans and senior faculty members of the affiliated medical and dental schools and other academic institutions as appropriate and representative(s) of the medical/dental staffs of VATVHS. They provide academic oversight and review professional appointments.

Annex: A community based clinic within 5 miles of either of the main campuses at Murfreesboro or Nashville.

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

Associate Director: The Associate Director fulfills the responsibilities of the Director as defined in these bylaws when service in the capacity of Acting Facility Director.

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

Automatic Suspension of Privileges: Automatic suspensions are enacted whenever the defined indication occurs. They do not require discussion, investigation or reporting if less than 30 days. Examples are exceeding the allowed medical record delinquency rate when such delinquency does not impact patient care or failure to maintain qualifications for appointment. Privileges are automatically suspended until the records are completed or the delinquency rate falls to an acceptable level. Reactivation must be endorsed by the Medical Executive Board.

Chief of Staff: The Chief of Staff is the individual appointed by the Governing Body whose responsibilities are both administrative and clinical in nature. Clinical responsibilities are

defined as those involving professional capability as a practitioner such as to require the exercise of clinical judgment with respect to patient care. The Chief of Staff is President of the Medical Staff and Chairperson of the Medical Executive Board. He/she collaborates with the Chief Operating Officers at the Nashville and Murfreesboro Campuses, and the Associate Director for Nursing in the formation and supervision of the administrative activities inherent in assigned services. He acts as a full assistant to the Director in the efficient management of clinical and medical services to eligible patients, the active maintenance of a medical credentialing and privileging and/or scope of practice system for Licensed Independent Practitioner, Mid-level Practitioners and Associated Health Practitioners. The Chief of Staff ensures the ongoing medical education of medical staff.

Chief Operating Officers: The Chief Operating Officers fulfill the responsibilities of the Director as defined in these Bylaws when serving in the capacity of Acting Health System Director.

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

Credentialing: Credentialing is the systematic process of screening and evaluating qualifications and other credentials of applicants to assure that they possess the required education, training, license, registration, certification, experience, and skill to fulfill the requirements of appointment.

Director: The Director (Chief Executive Officer) is appointed by the Under Secretary for Health and the Secretary of the Department of Veterans Affairs to act on their behalf in the overall management of the VATVHS. The Director reports directly to the Network Director and is assisted by the Chief of Staff (COS), the Medical Executive Board (MEB), the Chief Operating Officers (COO), the Associate Director (AD), the Associate Director for Patient Care Services (AD-PCS) and the Associate Director for Nursing. The Director is chairperson of the Governing Council. The Director is responsible for ensuring local facility policy, including Medical Staff Bylaws and Medical Staff Rules and Regulations are consistent with the VHA Handbook 1100.19.

Functional Statement: An official statement of the major duties and responsibilities assigned by management to a position. It must contain all pertinent information related to the position to ensure accurate job-related documentation. The following positions are included but not limited to: audiologist, biomedical engineer, dental assistant, dental hygienist, dietician, diagnostic radiologic technologist, kinesiotherapist, licensed practical nurse, medical instrument technician,

medical record administrator, medical record technician, medical technologist, nuclear medicine technologist, clinical nurse specialist, occupational therapist, occupational therapy assistant, orthotist-prosthetist, pharmacist, pharmacy technician, physical therapist, physical therapy assistant, prosthetic representative, registered nurse, registered and certified respiratory therapist, social worker, speech pathologist, and therapeutic radiologist technologist.

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

Impaired Practitioner: An individual who is credentialed and privileged to provide direct patient care or does so under a scope of practice or functional statement but is unable to provide such care because of physical illness, mental illness or substance abuse.

Just Cause: Just cause is a burden of proof or standard that an employer must meet to justify discipline or discharge. Also known as Bare sagen, it is a common standard in labor arbitration that is used in labor union contracts in the United States as a form of job security. Typically, an employer must prove just cause before an arbitrator to sustain an employee's termination, suspension or other discipline. Usually, the employer has the burden of proof in discharge cases or if the employee is in the wrong.

Licensed Independent Practitioner: The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by the VATVHS to provide care and service without direction or supervision, within the scope of the individual's license and consistent with individually granted privileges. In this organization, this includes physicians, dentists and psychologists. It may also include individuals who can practice independently, who meet this criterion for independent practice.

Licensure: Licensure refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license or registration.

Medical Executive Board: Executive committee of the medical staff is chaired by the Chief of Staff and empowered to act on behalf of the medical staff. It carries out its work within the medical staff functions of governance, leadership, and performance improvement activities.

Medical Staff: The body of all Licensed Independent Practitioners and other Practitioners credentialed through the medical staff process who are subject to the medical staff Bylaws. This

body may include others, such as retired Practitioners who no longer practice in the organization but wish to continue their membership in the body. The medical staff includes both members of the organized medical staff and non-members of the organized medical staff who provide health care services.

Mentoring: Mentoring is a process for the informal transmission of knowledge, social capital, and the psychosocial support perceived by the recipient as relevant to work, career, or professional development. Mentoring entails informal communication, usually face-to-face and during a sustained period of time, between a person who is perceived to have greater relevant knowledge, wisdom, or experience (the mentor) and a person who is perceived to have less (the protégé).

Mid-Level Practitioner: Mid-Level Practitioners are those health care professionals who are not physicians and dentists and who, most often, function within a Scope of Practice but may practice independently on defined clinical privileges as defined in these Bylaws. Mid-Level Practitioners include: physician assistants (PA), Clinical Pharmacists (PharmDs), and advanced practice nurses (ARNP, CRNA, and CRNP). Mid-Level Practitioners may have prescriptive authority as allowed by Federal Regulation, and/or state of licensure statute and regulations, under the supervision of a credentialed and privileged Licensed Independent Practitioner when required. Mid-Level Practitioners do not have admitting privileges. Mid-Level Practitioners may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations. Advanced Registered Nurse Practitioners and other health care professionals may be granted defined clinical privileges when allowed by law and the facility.

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

On Site: On site refers to the main campuses at Murfreesboro and Nashville, and all CBOCs, including contract CBOCs and Annexes.

One Standard of Care**:** In the context of credentialing and privileging the requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same.

Organized Medical Staff: The body of Licensed Independent Practitioners 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.

Outpatient Clinic: An outpatient clinic is a healthcare site whose location is independent of medical facility, however; oversight is assigned to a medical facility.

Patient Safety**:** Patient Safety is ensuring freedom from accidental or inadvertent injury during health care processes. The goal is to prevent harm and injury to patients, visitors and personnel, and improve in the credentialing process.

Peer Recommendation: Information submitted by an individual(s) in the same professional discipline as the applicant reflecting their perception of the Practitioner's clinical practice, ability to work as part of a team, and ethical behavior or the documented peer evaluation of Practitioner-specific data collected from various sources for the purpose of evaluating current competence.

Performance Improvement: The term refers to the system-wide effort established by the healthcare system to ensure the highest quality of patient care delivery by assessing patient care and other support processes in a systematic, ongoing manner to identify improvement opportunities and address them in a timely manner.

Primary Source Verification: Primary source verification is 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 documented in the form of a letter, telephone contact, secure electronic communication with the original source, or when required by VA policy, it may be a transcript received directly from the issuing institution.

Privileging: The process by which a licensed independent practitioner (i.e., without supervision, direction, required sponsor, preceptor, mandatory collaboration, etc.) is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training and licensure. Privileges must be facility-specific and provider-specific.

Proactive Disclosure Service (PDS): Continuous monitoring service through the National Practitioner Data Bank (NPDB) that notifies subscribing entities when new or updated NPDB and/or Healthcare Integrity and Protection Data Bank (HIPDB) reports are received. PDS notifies subscribers of a report on their enrolled practitioners within 24 hours of receipt by the Data Bank.

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

Professional Standards Board (PSB): The Professional Standards Board acts as a Credentials Committee on credentialing and clinical privileging matters of the Medical Staff, making recommendation on such matters to the Medical Executive Board as defined in these Bylaws. The PSB also may act on matters involving Associated Health and Mid-Level Practitioners such as granting prescriptive authority, scope of practice, and appointment. Some professional standards boards (e.g. Nursing, Psychology, Pharmacy, etc) are responsible for advancement and other issues related to their respective professions. The Chief of Staff is Chairman of the PSB.

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 Medical Executive Board and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.

Scope of Practice**:** Scope of practice is a term used by state licensing boards for various professions that define the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency.

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

Telemedicine: The provision of care by a licensed independent health care provider that directs, diagnoses, or otherwise provides clinical treatment delivered using electronic communications and information technology when distance separates the provider and the patient.

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).

VetPro**:** VetPro is an Internet enabled data bank for the credentialing of VHA health care providers that facilitates completion of uniform, accurate and complete credentials file.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Department of Veterans Affairs Tennessee Valley Healthcare System (VATVHS).

ARTICLE II. PURPOSE

The purpose of the Medical Staff shall be to:

1. Assure that all patients treated at the VATVHS, receive safe, efficient, timely and appropriate care within the resources of the healthcare system, in accordance with the community standards of care, and subject to continuous quality improvement practices.

2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs will assure continuity of care and minimize institutional care.

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

4. Develop and adhere to system specific standards and mechanisms for appointment to the Medical Staff and delineation of clinical privileges.

5. Provide and prioritize system-sponsored educational activities that relate to type and nature of care, treatment and services provided, findings of quality of care review activities, findings of performance improvement and expressed needs of caregivers and recipients of care

6. Ensure a high level of professional performance of practitioners authorized to practice in the facility, through the appropriate delineation of clinical privileges, the ongoing review and evaluation of each practitioner's performance, and continuous quality improvement practices.

7. Assist the Medical Executive Board and the Governing Council in developing and maintaining rules for Medical Staff governance and oversight and provide a means whereby problems of a medical-administrative nature may be discussed by the Medical Staff and the Governing Body.

8. Provide clinical leadership in the management of deliberations of the VATVHS Director and Governing Body that impact patient care, policy, procedure, continuous performance improvement, organizational management and strategic planning.

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

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

11. Ensure licensed independent practitioners (LIPs) authorized to practice in the facility do so within their delineated clinical privileges.

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

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

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

15. Coordinate and supervise the scope of practice of all Mid-Level and appropriate Associated Health Practitioner staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each Mid-Level and appropriate Associated Health Practitioner should have a scope of practice statement or privileges as well as the means employed to coordinate and supervise their function with the medical staff.

16. Ensure associated health professionals practice within their authorized functional statement.

17. Provide medical backup to the Department of Defense in times of emergency.

18. Initiate and pursue corrective action with respect to members where warranted.

19. Establish and amend, as needed the Medical Staff Bylaws, Rules and Regulations, and policies for the effective performance of Medical Staff responsibilities.

20. Enforce and comply with Medical Staff Bylaws.

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 professionally competent, licensed physicians, dentists, optometrists, podiatrists, and clinical psychologists, who continually meet the qualifications, standard and requirements of VHA, VATVHS, and these Bylaws. The Director, based on recommendations from the Medical Executive Board, may consider membership for other licensed independent practitioners who are permitted by law to provide patient care service independently and who meet the qualifications, standards and requirements of VHA, VATVHS, and these Bylaws, Rules and Regulations.

2. **Categories of the Medical Staff**:

a. Active Medical Staff consists of full-time and part-time physicians, dentists, optometrists, podiatrists and clinical psychologists who are professionally responsible for specific patient care and/or education and/or research activities at VATVHS and who assume all the functions and responsibilities of membership on the active staff. They may hold faculty appointments in the school of their discipline. They will actively participate in quality improvement activities required of the staff. Members of the active medical staff are appointed to a specific, professional medical staff service and are eligible to serve and vote on medical staff committees. A member will satisfy the requirements for attendance at meetings of the Medical Staff, the service, and committees they are assigned.

b. Associate Medical Staff shall consist of intermittent, consultants, telemedicine consultants, contract, fee basis, and without compensation (WOC) staff who complement the members of the active Medical Staff in their roles in patient care, education and research. Members of the associate Medical Staff are appointed to specific professional medical staff services. The associate staff members are not required but are eligible to serve and vote on Medical Staff committees. They may attend the meetings of the Medical Staff but cannot vote.

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

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

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

a. Active, current, full and unrestricted license to independently practice the individual's profession in a State, Territory or Commonwealth of the U.S. or the District of Columbia as required by VA employment policies and procedures, or limited, institutional state license expressly stating that the individual may practice at this healthcare system as per the exceptions listed for the full and unrestricted license requirements listed in VA Handbook 5005, Part II, Chapter 3, paragraph 4b. Failure to maintain at least one unrestricted license and/or involuntary termination of any license will result in automatic termination of the practitioner's clinical privileges and appointment to TVHS.

b. Education applicable to individual medical staff members as defined, e.g., hold a degree of Doctor of Medicine or equivalent (MBBS), Osteopathy, Dentistry, Optometry, Podiatry or a doctoral degree in Psychology 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 (see policy on "Basic Life Support and Advanced Cardiac Life Support Training").

d. Current competence consistent with the individual's assignment and the privileges for which applying, including recent privileges held. For new appointments to the medical staff, current competence is documented by recommendations from peers and supervisors, attesting to the applicant's ability to perform satisfactorily the privileges requested.

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

f. Complete information consistent with the requirements for application and clinical privileges as defined in Articles VI and VII of these Bylaws and the healthcare system policy on Credentialing and Privileging for a position for which VATVHS has the patient care need, adequate facilities, support services and staff.

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

h. Proficiency in the English language must be demonstrated.

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

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

k. Ability to meet response time criteria established for the service as applicable.

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

a. The following Practitioners will be credentialed and privileged to practice independently:

(1) Physicians

(2) Dentists

(3) Psychologists

(4) Optometrists

(5) Podiatrists

b. The following Practitioners will be credentialed and may be privileged to practice independently if in possession of State license/registration that permits independent practice and authorized by this Facility:

(1) Doctors of Pharmacy

(2) Clinical Pharmacists

c. The following Practitioner will be credentialed and will practice under a Scope of Practice with appropriate supervision:

Physician Assistants.

d. The following Practitioners will be credentialed and will practice under a Scope of Practice with appropriate supervision when not granted clinical privileges as in b above.

(1) Advanced Practice Nurses

(2) Clinical Social Workers

(3) Audiologists

(4) Speech Pathologists

(5) Advanced Practice Nurses

(6) Clinical Social Workers

(7) Audiologists

(8) Speech Pathologists

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

Section 3.03 Code of Conduct

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

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

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

VA distinguishes BUCS 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 BUCS 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 BUCS 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

1. Licensed independent practitioners, both members and non-members of the Medical Staff, are accountable for and have responsibility for:

a. Providing for continuous care of patients assigned to their care and to arrange for transfer of care when appropriate. The care should be of the quality and efficiency generally recognized as standard within his/her profession and area of expertise.

b. Observing patient's rights in all patient care activities.

c. Participating in the improvement in organizational performance and patient safety through active participation in continuing education, peer review, patient incident reporting, Medical Staff monitoring and evaluation and the organization wide Systems Redesign Program. Members of the Medical Staff have a responsibility to contribute to, actively participate in, and, where appropriate, lead process improvement activities.

d. Maintaining standards of ethics and ethical relationships including a commitment to:

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

(2) Provide care to patients within the scope of privileges or scope of practice and advise the Director through the Chief of Staff of any changes in ability to fully meet the criteria for Medical Staff membership or to carry out clinical privileges held or functions delineated in a scope of practice. When a clinical issue or problem is outside the practitioner's clinical privileges or scope of practice, he/she must seek consultation from a practitioner with the appropriate privileges or from his/her supervisor.

(3) Advise the VATVHS Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of notification of such occurrences and their outcome consistent with requirements under Article IV of these Bylaws.

(4) Contribute to, and abide by, high standards of ethics in professional practice and conduct applicable to the individual's discipline of training, e.g., AMA, ADA.

(5) Abide by the established guidelines for supervision of participants in the professional graduate education programs. (Refer to policy on graduate medical education, associated health professionals)

e. Prepare and complete, in a timely manner, the required clinical records of all patients for whom he/she provides care at this medical center.

f. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the VATVHS and VHA.

g. Apply for renewal of clinical privileges within the time frame allowed (preferably at least three (3) months in advance) to ensure that current privileges do not lapse.

Section 3.05: Conflict Resolution and Management

For the VA to be effective and efficient in achieving its goals the organization must have clear objectives and a shared vision of what it is striving to achieve. Therefore, there must be a mechanism for the recognition of conflict and its resolution in order to make progress in meeting these established goals. Conflict Management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. VA Handbook 5978.1, *Alternative Dispute Resolution Program*, addresses the conflict resolution and management process available in the VA, as well as resources to engage in mediation as well as non-binding or binding arbitration. VHA expects VA medical center leadership to make use of these and other resources in communicating expectations to clinicians and other staff the conflictive, disruptive, inappropriate, intimidating and uncivil behavior can compromise VHA's mission of high quality health care service to Veterans. VA staff who experience or witness such behavior are encouraged to advise an appropriate supervisor, Patient Safety Officer or other individual as described in the following Agency resources: Memorandum on Alternative Dispute Resolution for Workplace Disputes (February 8, 2007), VA Directive 5978 and VA Handbook 5978.1.

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

1. The only officer of the Medical Staff is the Chief of Staff, who functions as the President and chairs the Medical Executive Board. He/she is a member of the Academic Partnership Council. The Chief of Staff is a member of the Medical Staff, appointed by the Governing Body whose responsibilities are both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a practitioner such as to require the exercise of clinical judgment with respect to patient care. The Chief of Staff is President of the Medical Staff. He/she collaborates with the Chief Operating Officers at the Nashville and Murfreesboro Campuses, and the Associate Director for Nursing in the formation and supervision of the administrative activities inherent in assigned services. The method of selection, qualifications, and responsibilities, tenure in office, and conditions and mechanisms for removing from office will be in accordance with applicable VHA Handbook 5005; and VHA M-2, Part 1, Chapter, "Chief of Staff Responsibilities."

2. The Deputy Chief of Staff is fully responsible to the VATVHS Chief of Staff to provide oversight and leadership for the clinical, teaching and research functions at TVHS. The Deputy Chief of Staff's responsibilities include coordinating programs with the Vanderbilt Medical School, Meharry Medical School and enhancing clinical and research programs in the TVHS. Specific assignments will reflect workforce development and succession precepts for potential future advancement.

3. Medical Staff Leadership, Chairs of Medical Staff Committees, and all service-level staff with responsibility for the credentialing and privileging process complete the one time training determined by the Office of Quality and Performance (OQP) within 3 months of assuming their position. This training is accessed through the VA Learning Management System. It also includes the Chief of Staff, System Director, Credentialing staff, and Quality Management professionals (specialists and Chief, QMS), including the Risk Manager.

Section 4.02 Leadership

1. The Chief of Staff is fully responsible to the VATVHS Director for programs of patient care and for the educational and research activities of the clinical services. To carry out these responsibilities, the Chief of Staff:

a. Formulates and recommends plans for a comprehensive program of medical care.

b. Develops the requirements of staff, facilities, equipment and supplies needed to carry forward such an integrated program, utilizing necessary reviews and controls.

c. Appraises the effectiveness of the various medical programs in meeting the needs of patient care.

2. The Deputy Chief of Staff is fully responsible to the VATVHS Chief of Staff to provide oversight and leadership for the clinical, teaching and research functions at TVHS. The Deputy Chief of Staff's responsibilities include coordinating programs with the Vanderbilt Medical School, Meharry Medical School and enhancing clinical and research programs in the TVHS. Specific assignments will reflect workforce development and succession precepts for potential future advancement.

3. The Organized Medical Staff, through its committees 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.

Section 4.03 Clinical Services

1. Characteristics:

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

b. Clinical Services hold service-level meetings at least monthly with a minimum of 10 per year.

c. The Medical Staff shall be organized into services or care lines. Each medical staff service shall function under the leadership of the Service Chief. A service may be further divided, as appropriate, into sections which shall be directly responsible to the service chief within the service in which it functions. When appropriate, the Chief of Staff may recommend to the VATVHS Director for his/her approval the creation, modification, elimination, or combination of services or sections.

d. Medical Staff Services/Care Lines include:

(1) Anesthesiology

(2) Dental

(3) Geriatrics and Extended Care Line

(4) Medical Imaging Service

(5) Medicine

(6) Mental Health Care Line

(7) Neurology

(8) Pathology and Laboratory Medicine

(9) Physical Medicine and Rehabilitation

(10) Primary Care

(11) Surgery

(12) Transplant

e. Each Medical Staff Service/Care Line provides patient care according to its written goals and Scope of Services as approved by the Medical Executive Board and VATVHS Director.

2. Functions:

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

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

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

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

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

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

g. Annually review privilege templates for each Service and make recommendations to MEB.

3. Selection and Appointment of Service Chiefs: Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff.

a. Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff. Service Chiefs shall be board certified by the appropriate specialty board or possess comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. They are appointed by the VATVHS Director, based upon the recommendation of the Chief of Staff, and approved by the VISN 9 Executive Resource Board, and, if appropriate, the VHA Headquarters Program Director.

b. Service Chiefs who are not a physician or dentist will be assisted by a Senior Physician or Dentist who must meet qualifications established by the Professional Standards Board.

c. Board certified if applicable in the clinical specialty area in which they will practice is preferred as an objective indication of clinical skill and a measure of quality in the delivery of

patient care. Physicians who are not board certified or eligible for board certification may be appointed as outlined in VHA Handbook 1100-19, Credentialing and Privileging. Clinical Service Chiefs must be board certified, if applicable, by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty not appropriate for the assignment, the PSB affirmatively establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. Appointment of service chiefs without board certification will comply with the VHA policy for these appointments as appropriate (Element 36 – Qualifications).

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

a. Completing Medical Staff Leadership and Provider Profiling on-line training within three months of appointment as Service Chief.

b. Clinically related activities of the Service.

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

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

e. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service.

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

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

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

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

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

k. The assurance of a sufficient number of qualified and competent persons to provide care, treatment, and service.

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

m. The continuous assessment and improvement of the quality of care, treatment, and services.

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

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

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

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

r. Assuring appropriate supervision of House Staff assigned to the Service consistent with rules, regulations and policies.

s. Participation as a member of the Medical Executive Board.

t. Supervision and identification of medical staff that have been granted disaster privileges when the VATVHS Director has activated the Emergency Management Plan.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

1. Committees are either standing or special.

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

3. The presence of 50% of a committee's members will constitute a quorum.

4. The members of all standing committees, other than the MEB, are appointed by the Chief of Staff subject to approval by the MEB, unless otherwise stated in these Bylaws.

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

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

Section 5.02 Medical Executive Board

1. **Characteristics**: The Medical Executive Board (MEB) serves as the Executive Committee of the Medical Staff. The members of the MEB are:

a. Chief of Staff, Chairperson, voting

b. Clinical Service Chiefs, voting

(1) ACOS, Ambulatory Care

(2) ACOS, Education

(3) ACOS, Geriatrics and Extended Care

(4) ACOS, Research and Development

(5) Chief, Anesthesiology Service

(6) Chief, Dental Service

(7) Director, GRECC

(8) Chief, Medical Imaging Service

(9) Chief, Medicine Service

(10) Chief, Mental Health Care Line

(11) Chief, Neurology Service

(12) Chief, Pathology and Laboratory Medicine Service

(13) Chief, Physical Medicine and Rehabilitation

(14) Chief, Primary Care

(15) Chief, Surgery Service

(16) Practitioners appointed through the medical staff process

(17) Director, or designee, ex-officio, non-voting

(18) Nurse Executive, ex-officio, non-voting

c. Other facility staff as may be called upon to serve as resources or attend committee meetings at the request of the chairperson, with or without vote. The non-voting members include:

(1) Chief, Audiology and Speech Pathology Service

(2) Chief, Chaplain Service

(3) Chief, Clinical Informatics Officer

(4) Chief, Education Service (DLO)

(5) Chief, Nutrition and Food Service

(6) Chief, Pharmacy Service

(7) Chief, Quality Management Service

(8) Chief, Social Work Service

(9) Compliance Officer

(10) Administrative Assistant to the Chief of Staff

(11) Representative, AFGE 1844

(12) Representative, AFGE 2400

d. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

2. **Functions of the MEB:** The MEB:

a. Acts on behalf of the Medical Staff between Medical Staff meetings within the scope of its responsibilities as defined by the Organized Medical Staff.

b. Maintains process for reviewing credentials and delineation of clinical privileges and/or scopes of practice to ensure authenticity and appropriateness of the process in support of clinical privileges and/or scope of practice requested; to address the scope and quality of services provided within the facility.

c. Acts to ensure effective communications between the Medical Staff and the Director.

d. Makes recommendations directly to the Director regarding the:

(1) Organization, membership (to include termination), structure, and function of the Medical Staff.

(2) Process used to review credentials and delineate privileges for the medical staff.

(3) Delineation of privileges for each Practitioner credentialed.

e. Coordinates the ongoing review, evaluation, and quality improvement activities and ensures full compliance with Veterans Health Administration Clinical Performance Measures, The Joint Commission, and relevant external standards.

f. Oversees process in place for instances of "for-cause" concerning a medical staff member's competency to perform requested privileges.

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

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

i. Monitors medical staff ethics and self-governance actions.

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

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

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

m. Acts upon recommendations from the PSB.

n. Acts as and carries out the function of the Physical Standards Board, which includes the evaluation of physical and mental fitness of all medical staff upon referral by the Occupational Health Physician. The Physical Standards Board may have the same membership as the local physician Professional Standards Board or members may be designated for this purpose by the Health System Director. Boards may be conducted at other VA healthcare facilities.

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

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

3. **Meetings**:

a. **Regular Meetings**: Regular meetings of the MEB shall be held at least nine times per year with meetings following every scheduled PSB meeting. 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 MEB 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 MEB.

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

c. **Meeting Notice**: All MEB members shall be provided at least 3 days advance written notice of the time, date, and place of each regular meeting and reasonable notice, oral or written, of each emergency meeting.

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

e. **Quorum**: A quorum for the conduct of business at any regular or emergency meeting of the MEB shall be a majority of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority (50%) vote at any meeting at which a quorum (50%) is present. The majority of the voting members must be fully licensed physicians of medicine or osteopathy.

f. **Minutes**: Written minutes shall be made and kept on all meetings of the MEB, and shall be open to inspection by Practitioners who hold membership or privileges on the Medical Staff.

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

4. **Method of Removing Members**: Members of the medical staff can be removed after a two-third's vote at the MEB and will be notified in writing by the Chief of Staff of the removal.

Section 5.03 Committees of the Medical Staff

1. Reporting committees provide a major framework by which the Medical Staff accomplishes performance improvement functions for clinical processes. These committees meet on a frequency as determined by the MEB and medical center policy. Committees prepare and maintain records for discussion, conclusion, recommendations, and action and results of actions taken and are responsible for timely communication of committee activities through channels established by the Medical Staff. Medical Staff, or their designated alternates, are encouraged to attend committee meetings to which they are assigned.

2. Reporting committees are defined in the Medical Executive Board policy. Committee meetings will specify those members in attendance and identify reporting frequency to the MEB.

a. Professional Standards Board of the Medical Staff

(1) Membership. The Professional Standards Board (PSB) is the designated hospital credentialing committee for physicians, dentists, podiatrists, optometrists, clinical psychologists, advanced practice nurses (NPs, CNS, CRNAs), clinical pharmacy specialists, and physician assistants. There are chartered PSBs for various disciplines that report to the Medical Staff PSB. Membership includes the Chief of Staff, Deputy Chief of Staff, designated Clinical Service and

Section Chiefs, a representative from Credentialing and Privileging, a representative from Human Resources Management Service, and the Service or Section Chief representing the specialty of the individual whose credentials are under review. A quorum is 50 percent of voting members and must be present to make recommendations to the VATVHS Director (see policy Professional Standards Board) and must meet at least 12 times per year.

(2) Functions.

(a) The PSB is constituted to examine all documents and pertinent information concerning the appointment, advancement, and probationary review of clinical staff to ensure that the VHA recruits and retains the best-qualified professional personnel. Its functions include, but are not limited to:

(1) Review and recommend action to the Director for acceptance or rejection of each application for appointment and action on each request for initial privileges.

(2) Review and recommendation on proposals for special advancement for performance and/or

achievement for members of the Medical Staff.

(3) Review and recommend to the VATVHS Director, in accordance with the Professional Standards Board policy and appropriate VHA Directives and supplements thereto, action on all policies and procedures for appointment, promotion, and advancement of Title 38 associated health professionals.

(b) Composition of the Chartered Boards – Whenever possible, the chartered professional standards boards will be composed of three or five employees from the same occupation as the individual being considered. However, appropriately qualified individuals from other occupations may be appointed, provided the board is composed of a majority of the employees from the occupation involved. When the appropriate minimum number of employees in the occupation is not available or the number of employees is too small to provide for an independent review, an alternate board must be used (VA Handbook 5005/17, Part II, Chapter 3, June 15, 2006).

b. **The Peer Review Committee**

The Peer Review Committee is defined in medical center policy 626-08-00Q-16. The Chief of Staff chairs this committee, oversees the Peer Review Program and is responsible for ensuring the committee functions and meets internal and external reporting requirements in accordance with VA guidelines. The Quality Management Service (QMS) facilitates the peer review process information flow including maintaining documentation and coordinating required reporting. The QMS is responsible for developing and providing quarterly aggregate summary reports of peer

review activity and report quarterly to the MEB in accordance with current VA frequency and format requirements and meets quarterly.

c. **Residency Review Committee:** The Residency Review Committee works with the Vice Chancellor's Committee (Nashville Campus) and the Academic Partnership Council (Alvin C. York Campus), the Associate Chief of Staff for Education, and the clinical services with residents to assure that patients whose care is provided by residents receive the same level of care as that which is provided by medical staff. The Residency Review Committee will assure that residents are given the opportunity to learn in an appropriate setting with appropriate supervision, that their performance meets the expected standards for their level of training, and that the residents observe the same ethical standards as the medical staff. The Committee will report to the PSB but will report at least annually to the MEB.

3. Other committees may be chartered and will need to include charge, composition and meeting frequency.

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

Section 5.04 Committee Records and Minutes

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

2. Each Committee provides appropriate and timely feedback to the Services relating to all information regarding the Service and its providers.

3. Each committee shall review and forward to the MEB, a synopsis of any subcommittee and/or workgroup findings.

Section 5.05 Establishment of Committees

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

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

ARTICLE VI. MEDICAL STAFF MEETINGS

1. **Regular Meetings**: Regular meetings of the Medical Staff shall be held at least annually. A record of attendance shall be kept. The Medical Staff must be convened by the Chief of Staff and meets, at a minimum, yearly. Additional meetings may be convened at the call of the Chief of Staff or at the request of the Medical Executive Board. Active Medical Staff members (5/8^{ths} or greater) should attend the annual meeting.

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

3. **Quorum**: For purposes of Medical Staff business, 25% of the total membership of the medical staff membership entitled to vote constitutes a quorum. A **quorum** is present when the number of attendees is equal to 51% of all members employed 5/8 FTE or greater.

4. **Meeting Attendance**: Members of the Organized Medical Staff are required to attend 50% of regular Medical Staff meetings and 50% of Service-level meetings.

5. **Medical Staff members** will attend their Service staff meetings and meetings of committees of which they are members unless specifically excused by the Service Chief or Chair, where appropriate, for appropriate reasons, e.g., illness, leave or clinical requirements.

6. **Members of the active Medical Staff** (5/8^{ths} or greater) are voting members. Every member's vote counts equally.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Section 7.01 General Provisions

1. **Independent Entity**: VA TVHS is an independent entity, granting privileges to the medical staff through the MEB and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Mid-Level Practitioner, and Associated Health Practitioner reappointments may not exceed 2 years, minus one day from the date of last appointment or reappointment date. Medical Staff, Mid-Level, and Associated Health Practitioners must practice under their privileges or scope of practice.

2. **Credentials Review**: All Licensed Independent Practitioners (LIP), Mid-Level and Associated Health Practitioners who will hold clinical privileges or scope of practice will be subjected to full credentials review at the time of initial appointment and reappraisal for granting of clinical privileges and after a break in service. All Mid-Level and Associated Health Practitioners will be subjected to full credentials review at the time of initial appointment, appraisal, or reappraisal for granting a scope of practice with prescriptive authority. Credentials that are subject to change during leaves of absence shall be reviewed at the time the individual returns to duty. Practitioners are appointed for a maximum period of 2 years minus one day.

3. **Deployment/Activation Status**:

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

b. After verification of the updated information is documented, the information will be referred to the Practitioner's Service Chief then forwarded to the MEB for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and Executive Committee to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.

c. In those instances where the privileges lapsed during the call to active duty, the Practitioner must provide additional references or information needed for verification and all verifications must be completed prior to reappointment.

d. In those instances where the Practitioner was not providing clinical care while on active duty, the Practitioner in cooperation with the Service Chief must consider the privileges held

prior to the call to active duty and whether a request for modification of these privileges should be initiated, on a short-term basis. These providers may be returned to a pay status, but may not be in direct patient care.

4. **Employment or Contract**: Appointments to the Medical Staff occur in conjunction with VHA employment or under a VHA contract or sharing agreement. The authority for these actions is based upon:

a. Provisions of 38 U.S.C. 7401 in accordance with VA Handbook 5005, Part II, Chapter 3, VHA Handbooks and applicable Agreement(s) of Affiliation in force at the time of appointment.

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

5. **Initial Focused Professional Practice Evaluation:**

a. The initial focused professional practice evaluation (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 request a new privilege. The performance monitoring process is defined by each Service and must include:

(1) Criteria for conducting performance monitoring

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

(3) Method for determining the duration of the performance monitoring

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

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

(1) Initial and certain another appointments made under 39 U.S.C. 7401(I), 7401 (3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance and conduct will be closely evaluated under applicable VA policies, procedures and regulations.

(2) If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and

managers apply the same processes to the evaluation of individuals employed under provision of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.

6. **Ongoing Professional Practice Evaluation**:

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.

(1) The timeframe for ongoing monitoring is to be defined locally. It is suggested that, at a minimum, service chiefs must be able to demonstrate that relevant practitioner data is reviewed on regular bases (i.e. more than once a year). Consideration may be based on a period of time or a specified number of procedures and may consider high risk or high volume for an adjustment to the frequency.

(2) With very few exceptions, VHA data standing alone is not protected by 38 U.S.C. 5705. Its use would dictate the appropriate protections under law. Data that generates documents used to improve the quality of health care delivered or the utilization of health care resources is protected by 38 U.S.C. 5705. Data that is not previously identified as protected by 39 U.S.C. 5705 and is collected as provider specific data could become part of a practitioner's provider profile, analyzed in the facility's defined on-going monitoring program and compared to predefined facility triggers or de-identified quality management data.

(3) 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.

(4) The MEB 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.

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

Section 7.02 Application Procedures

1. **Completed Application**: Applicants for appointment to the Medical Staff must submit a complete application. The applicant must submit credentialing information through VetPro as required by VHA guidelines. ***NOTE***: *See VHA 1100.19 for full process*. The applicant is bound to be forthcoming, honest and truthful (1100.19 page 9). To be complete, applications for appointment must be submitted by the applicant on forms approved by the VHA, entered into the internet-based VHA VetPro credentialing database, and include authorization for release of information pertinent to the applicant and information listed below. The applicant has the right to correct any information that is factually incorrect by documenting the new information with a comment that the previously provided information was not correct. Follow-up with the verifying entity is necessary to determine the reason for the discrepancy if the Practitioner says the information provided is factually incorrect.

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

(1) Active, current, full, and unrestricted license. ***Note:*** *In instances where Practitioners have multiple licenses inquiry must be made for all licenses and the process as noted in VHA Handbook 1100.19 must be followed for each license (38USC 7402). Limitations defined by state licensing authorities must also be considered when considering whether licensure requirements are met.*

(2) Education.

(3) Relevant training and/or experience.

(4) Current professional competence and conduct.

(5) Physical and Mental health status.

(6) English language proficiency.

(7) Professional liability insurance (contractors only).

(8) Proof of current BLS certification required for all on site physicians at the time of initial credentialing (excludes off-site teleradiologists and pathologists). See TVHS Memorandum BLS and ACLS Training Requirements for further categories of providers who require current BLS and ACLS training due to assignment to specific functions or areas of the facility.

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

(10) Laser Committee must approve all privileges for laser usage prior to approval of privileges by the PSB.

(11) Geriatrics Board will approve all privileges for providers practicing on the community living center units.

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

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

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

(1) Name of health care institution or practice.

(2) Term of appointment or employment and reason for departure.

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

e. **DEA/CDS Registration**: A description of:

(1) Status, either current or inactive.

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

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

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

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

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

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

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

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

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

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

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

e. Evidence and verification of board certification or eligibility, if applicable.

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

g. Evidence of registration with the National Practitioner Data Bank (NPDB) Proactive Disclosure Service and the Healthcare Integrity and Protection Data Bank, for all members of the Medical Staff and those Practitioners with clinical privileges.

h. For all physicians screening will be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening will report all licenses known to FSMB ever held by the physician. If the screen results in a disciplinary alert, primary source

information from the State licensing board for all actions related to the disciplinary alert as well as a statement from the Practitioner.

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

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

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

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

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

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

Section 7.03 Process and Terms of Appointment

1. **Chief of Service Recommendation**: The Chief of the Service or equivalent responsible person to which the applicant is to be assigned is responsible for recommending appointment to the Medical staff based on evaluation of the applicant's completed application, credentials, demonstrated competency, and a determination that Service criteria for clinical privileges are met.

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

3. **PSB Recommendation:** The PSB makes recommendations to the VATVHS Director, as delegated by the Medical Executive Board, for Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

4. **MEB Recommendation**: MEB recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

5. **Director Action**: Recommended appointments to the Medical Staff should be acted upon by the Director within 5 work days following approval of the MEB, unless there is a recommendation to not renew or to revoke privileges and 30 days is allotted for the Director's decision.

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

a. The applicant will be notified of the Director's decision to not renew or revoke privileges within 10 working days.

b. The applicant may appeal denial of the appointment, in writing to the VATVHS Director within 10 working days of receipt of the Director's decision.

7. When there is an emergent or urgent patient care need as defined in the healthcare system policy on Credentialing and Privileging, temporary VA employment appointment, under the provisions of 38 U.S.C. 7405(a)(1) and VA Handbook 5005, Part II, Chapter 3, paragraph B1f(2), and a temporary Medical Staff appointment may be approved by the VATVHS Director upon recommendation of the Chief of Staff prior to receipt of references or verification of other information and action by the PSB, when applicable. Verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted, initiation of a PDS query and a reference are required prior to making such an appointment.

8. An expedited appointment process may be used in instances where expediting a medical staff appointment is in the best interest of quality patient care. This is a one-time appointment process for initial appointment to the medical staff and may not exceed 60 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 60 calendar days of the expedited appointment or the medical staff appointment is automatically terminated.

a. The expedited appointment credentialing process cannot begin until the LIP completes the credentialing package, including but not limited to:

(1) Complete submittal by the applicant of credentials information into VetPro

(2) Confirmation of the practitioner's education and training

(3) Current license verified by the primary source

(4) Physical and mental health status confirmation

(5) Query of licensure history through the Federation of State Medical Boards Action Data Center

(6) Two peer references

(7) Current comparable privileges held in another institution

(8) Proactive Disclosure Service query

b. The authority to render a recommendation on an expedited appointment for the Director's approval is delegated by the MEB to at least 3 members of the PSB. Two of these members must also be members of the MEB and the third must be the Human Resources Management representative to the PSB.

c. No application will be denied because of race, creed, gender or national origin.

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

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

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

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

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

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

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

(1) Criteria for conducting the FPPE.

(2) Method for monitoring for specifics of requested privilege.

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

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

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

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

(1) Extension of FPPE review period

(2) Modification of FPPE criteria

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

(4) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported).

Section 7.05 Local/VISN-Level Compensation Panels

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

Section 7.06 Denial of Medical Staff Appointment

1. The Professional Standards Board, Chief of Staff, or the VATVHS Director may initiate certain corrective actions with regard to Medical Staff members whenever it is deemed in the best interest of patient care and to ensure effective self-governance. These actions may include but are not limited to personnel counseling, mandatory CME additional training or periods of supervision. In addition, service or hospital monitoring information may warrant recommendation for adverse privilege action.

2. The Medical Staff provides for the proctoring or supervision of procedures approved for individuals who have not met minimum service criteria. In accordance with State Licensing Boards and these Bylaws, the Medical Staff will ensure that practitioners meet continuing

education requirements for their specialty. The Medical Staff will also encourage referral of physicians to the Employee Assistance Program when circumstances indicate participation.

ARTICLE VIII. CLINICAL PRIVILEGES

Section 8.01 General Provisions

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

2. Reappraisal of privileges is required of each Medical Staff member and any other Practitioner who has clinical privileges. Reappraisal is initiated by the Practitioner's Service Chief at the time of a request by the Practitioner for new privileges or renewal of current clinical privileges.

a. Although the reappraisal process occurs biennially, ongoing professional practice evaluation is designed to continuously evaluate a Practitioner's performance.

b. Reappraisal requires 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 MEB. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (1100.19 page 7).

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

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

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

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

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

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

9. **Telemedicine**: As identified in VHA Handbook 1100.19, Credentialing and Privileging and related VISN policies, telemedicine practitioners, who render care through the use of electronic audio, video or other technologies to provide or support clinical care at distance, are credentialed and privileged through the medical staff mechanisms defined in these Bylaws. The Medical Staff determines which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards. This determination will be made through the Medical Executive Board and documented in the minutes.

10. **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.

11. The delineation of clinical privileges must be facility specific, setting specific and provider specific.

12. Each service chief must establish eligibility criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility. The criteria are determined by the service, recommended by the MEB and approved by the facility Director. These criteria for delineation and granting of privileges are reviewed on an annual basis. Privileges are setting specific, within the context of each facility, requiring consideration of each unique setting's characteristics, such as adequate facilities, equipment, and number and type of qualified support staff and resources.

13. Individuals performing procedures outside of the scope of granted privileges may be subject to disciplinary or administrative action. Clinical privileges may be temporarily restricted or suspended when patient safety or other considerations make it necessary and prudent to do so. Service Chiefs may take such action emergently after consultation with the Chief of Staff (see VHA Handbook 1100.19, Credentialing and Privileging).

14. The requesting and granting of clinical privileges for Chiefs of Staff or facility Directors must follow the procedures as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant service chief responsible for the particular specialty area in which they are requesting privileges. When considering clinical privileges for the COS an appropriate practitioner must chair the PSB and the COS must be absent from the deliberations. For a facility Director requesting privileges, the approval authority is delegated to the Associate Director (Chief Operating Officer), who is authorized to act as facility Director for these purposes.

15. Credentialing of Providers Delivering Care Off-Station

a. Fee Program (non-contracted) - The VA refers the veteran to the community and acts as a third party payer. The patient picks the provider and the VA assumes the cost for the care that was authorized. Since the VA is not directing care, the providers do not need to be credentialed and privileged by the VA.

b. Referral to a Specific Provider Group – The VA refers a veteran to a provider group using a contract. As long as the workload is distributed to two or more members of the group and not directed to a single provider in the group, the care is not directed by the VA and the providers are not credentialed and privileged by the VA. The VA is required to monitor the contract to assure that care is distributed among two or more members of the group and not misdirected to a specific provider. If the contract monitoring finds that one person is providing all the service, the person must be credentialed and privileged by the VA.

c. Referral to a Specific Provider – The referral from the VA can be through fee, contract or based on available community services. Because the workload is directed to a single provider, the provider must be credentialed and privileged since the VA is directing the care and chooses to provide the necessary care using this provider.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. **Burden of Proof:** When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper

evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.

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

3. Credentialing and privileging folder will be established and maintained for each practitioner requesting privileges. These folders will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging not found in VetPro. Any time that a folder is found to lack required documentation for any reason, an effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the folder stating the reason. The entry will also detail the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort. Additionally, a Vet Pro account will be maintained for each credentialed provider.

4. **Credentialing Application**: The Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:

a. Complete appointment information as outlined in Section 2 of Article VI.

b. Application for clinical privileges as outlined in this Article.

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

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

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

f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits

or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.

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

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

i. Evidence of current successful completion of an approved BLS program meeting the criteria of the American Heart Association is required at the time of initial appointment. Off-station practitioners, such as pathologists and teleradiologists, are exempt from this requirement.

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 the Bylaws and Rules.

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.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

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

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

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

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

d. Documentation of continuing medical education related to area and scope of clinical privileges, (consistent with minimum state licensure requirements) not previously submitted.

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

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

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

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

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

a. Current and previously held licenses in all states.

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

c. NPDB-HIPDB PDS Registration.

d. FSMB query

e. Physical and mental health status information from applicant.

f. Physical and mental health status confirmation.

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

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

i. Board certifications, if applicable.

j. Quality of care information.

Section 8.04 Processing an Increase or Modification of Privileges

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

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

3. Current NPDB-HIPDB PDS Registration prior to rendering a decision.

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

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

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

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

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

(1) Medical/Clinical knowledge (education competency).

(2) Interpersonal and Communication skills (documentation; patient satisfaction).

(3) Professionalism (personal qualities).

(4) Patient Care and Procedural Skills (clinical competency).

(5) Practice-based Learning & Improvement (research and development).

(6) 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. MEB recommends granting clinical privileges to the Facility Director based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. A subcommittee of MEB can make the initial review and recommendation but this information must be reviewed and approved by the MEB.

4. Clinical privileges are acted upon by the Director within 5 business days of receipt of the MEB 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 is given to the Practitioner and is readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.

6. PSB recommends scope of practice for practitioners with prescribing authority for concurrence to MEB for approval by the Director.

7. Renewal of clinical privileges shall also be based upon:

a. Physical and mental health status as it relates to practitioner's ability to function within privileges requested including such reasonable evidence of health status that may be required by the Professional Standards Board.

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

c. Documentation of a minimum of 40 hours of continuing education every two years related to area and scope of clinical privileges, not previously submitted.

d. Status of all licenses, certifications held.

e. Any sanction(s) by a hospital, state licensing agency or any other professional health care organization; voluntary or involuntary relinquishment of licensure or registration; any malpractice claims, suits, or settlements (including those pending outcomes); reduction or loss of privileges at any other hospital.

f. Compliance to all other provisions of these Bylaws.

8. Verification

a. Initial privilege verification will be accomplished as described in Section 2 of this Article.

b. Reprivileging verification will be accomplished by primary source confirmation of the following as applicable:

(1) All current licensure registrations at the time of appointment and initial granting of clinical privileges, at reappointment, renewal, or revision of clinical privileges, and at the time of expiration.

(2) Current DEA certification.

(3) Proactive Disclosure Service, NPDB-HIPDB, and Federation of State Medical Board queries.

(4) Board Certification obtained within the last 2 years.

9. The renewal of clinical privileges process also includes the updating of information maintained in VetPro.

Section 8.06 Exceptions

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

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

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

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

(3) Current comparable clinical privileges at another institution.

(4) Response from NPDB-HIPDB PDS registration with no match.

(5) Response from FSMB with no reports.

(6) No current or previously successful challenges to licensure.

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

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

(9) 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 a member of the Medical Staff 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. Properly supervised house staff may also provide emergency care.

3. **Organ Procurement**: Practitioners designated by the organ procurement organization with which the healthcare system has an authorized memorandum of agreement who are engaged solely at the healthcare system in organ and/or tissue recovery are exempt from requirements to obtain Medical Staff privileges for this purpose. The organ procurement organization is required to certify to the Director or hospital staff involved with the donation that such practitioners are appropriately licensed, insured and authorized to engage in organ and/or tissue recovery.

4. **Disaster Privileges**: As described in the Emergency Management Plan.

a. In the event of the implementation of the organization-wide disaster management plan, Disaster Privileges may be approved by the Director if it is determined that it is not possible to handle the influx of patients with the existing Practitioners. Any of the following will be accepted as credentials verification process for emergency volunteers to provide patient care in the facility:

(1) Evidence of a current license (pocket card sufficient) to practice.

(2) And one of the following:

(a) A current medical facility photo ID card.

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

(c) Identification that the individual has been granted authority to render patient care in emergency circumstances by a Federal, state, or municipal entity.

(d) Volunteer Licensed Independent Practitioners (LIP) will be given special ID badges stating "Disaster Volunteer" identifying them from other LIPs. The badges will be provided by Police and Security.

(e) The disaster privileges will be terminated immediately upon termination of the declared disaster or at the end of 10 calendar days, whichever is sooner. At the end of this period, the practitioner must be converted to temporary privileges, defined in these Bylaws, or relieved of duty.

(3) Consideration and approval of an initial request for privileges may proceed in conjunction with an expedited appointment as described in the policy on Credentialing and Privileging.

(4) The documentation will serve as credentials verification for a period not to exceed ten (10) calendar days or length of the disaster, whichever is shorter. Primary source verification of licensure will be obtained within seventy-two (72) hours after the disaster is under control, or as soon as possible in extraordinary circumstances.

(5) In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the 10 calendar days or the length of the declared disaster, whichever is shorter, noted in paragraph b above, the Practitioner must be converted to Temporary Privileges in accordance with VHA Handbook 1100.19, Credentialing and Privileging, for a period not to exceed 60 working days.

(6) An assigned, appropriately credentialed and privileged physician oversees the professional practice of each volunteer, Licensed Independent Practitioner, Mid-Level Practitioner, and Associated Health Practitioner.

(7) The quality of the care and service rendered by each volunteer Practitioner with Disaster Privileges must be evaluated at the end of 72 hours and a determination made as to whether or not the Practitioner will be permitted to continue providing services.

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

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

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

6. **Deployment and Activation Privilege Status**: In those instances where a Practitioner is called to active duty, the Practitioner's privileges are placed in a Deployment and/or Activation Status. The credential file remains active with the privileges in this new status. If at all possible, the process described below for returning privileges to an active status is communicated to the Practitioner before deployment. ***NOTE:*** *No step in this process should be a barrier in preventing the Practitioner from returning to the Facility in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994*.

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 MEB for review and recommendation. The documents reviewed, the determination, and the rationale for the determination of the MEB 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:

(1) 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.

(2) Registration with the NPDB-HIPDB PDS with no match.

(3) A response from the FSMB with no match.

(4) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation.

(5) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 60 calendar days.

7. **Residents or fellows** who are appointed outside of their training program to work on a fee basis as Medical or Psychiatric Officer of the Day, perform Compensation and Pension exams, or in the Emergency Department must be licensed, credentialed and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program, and must meet the same requirements of all Medical Staff appointed at the facility.

Section 8.07 Medical Assessment

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

ARTICLE IX. INVESTIGATION AND ACTION

1. **Request for Investigation**: Whenever the behaviors, activities and/or professional conduct of any Practitioner with delineated clinical privileges are considered to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff, or to represent Professional Misconduct, Behavior or Behaviors That Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these Bylaws, investigation of such Practitioner may be requested by the Chief of any clinical Service, the Chair of any standing committee of the Medical Staff, the Chief of Staff or the Facility Director. All requests for investigation must be made in writing to the Chief of Staff supported by reference to specific activities or conduct, which constitute the grounds for the request. The Chief of Staff promptly notifies the Director in writing of the receipt of all requests for corrective action. Material that is obtained as part of a protected performance improvement program (i.e., under 38 U.S.C. 5705), may not be disclosed in the course of any action to reduce or revoke privileges, nor may any reduction or revocation of privileges be based directly on such performance improvement data. If such information is necessary to support a change in privileges, it must be developed through mechanisms independent of the performance improvement program, such as administrative reviews and boards of investigation. In these instances, the performance improvement data may have triggered the review; however, the quality improvement information is confidential and privileged in accordance with 38 U.S.C. 5705, and therefore must be rediscovered through the administrative review or investigation process. ***NOTE***: *If the person under review, is an employee then the processes must also follow VA Directive 5021 - Management of Employees (Appendix A pages 2-9).*

2. **Fact Finding Process**: Whenever the Chief of Staff receives a request for investigation as described in paragraph 1 of this Article IX, a fact finding process will be implemented. This fact-finding process should be completed within 30 days or there needs to be documentation as to why that was not possible. If the results of the fact-finding process indicate that there is reasonable cause to believe that the behaviors, activities and/or professional conduct the Practitioner are likely to be detrimental to patient care, to pose a threat to patient safety, to be lower than the standards of the Medical Staff or to represent Professional Misconduct, Behavior or Behaviors That Undermine a Culture of Safety, or Inappropriate Behavior, as defined in these

Bylaws, the Chief of Staff may impose a summary suspension of privileges in accordance with the Medical Staff Bylaws and will initiate a review by the Professional Standards Board.

3. **Review by Professional Standards Board**: The Professional Standards Board investigates the charges and makes a report of the investigation to the MEB within 14 calendar days after the PSB has been convened to consider the request for corrective action. Pursuant to the investigation, the Practitioner being investigated has an opportunity to meet with the PSB to discuss, explain or refute the charges against him/her. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. An investigation by the PSB is an administrative matter and not an adversarial Hearing. A record of such proceeding is made and included with the committee's findings, conclusions and recommendations reported to the MEB.

4. **MEB Action**: Within 14 calendar days after receipt of a report from the PSB, the MEB acts upon the request. If the action being considered by the MEB involves a reduction, suspension or revocation of clinical privileges, or a suspension or revocation of Medical Staff membership, the Practitioner is permitted to meet with the MEB prior to the committee's action on such request. This proceeding does not constitute a Hearing and none of the procedural rules set forth in Article X of these Bylaws apply thereto. A record of such proceeding is made by the MEB.

a. The MEB may reject or modify the recommendations; issue a warning, a letter of admonition, or a letter of reprimand; impose terms of probation or a requirement for consultation; recommend reduction, suspension or revocation of clinical privileges; recommend that an already imposed suspension of clinical privileges be terminated, modified or sustained; or recommend that the Practitioner's staff membership be suspended or revoked.

b. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

c. Reduction of privileges may include, but not be limited to, functioning under supervision[1], restricting performance of specific procedures or prescribing and/or dispensing controlled substances. Reduction of privileges may be time limited and/or have restoration contingent upon some condition, such as demonstration of recovery from a medically disabling condition or further training in a particular area.

d. Revocation of privileges refers to the permanent loss of clinical privileges.

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

5. **Summary Suspension of Privileges**: The Director has the authority, whenever immediate action must be taken in the best interest of patient care, to summarily suspend, for cause, or portion of a Practitioner's delineated clinical privileges. Such suspension shall become effective immediately upon imposition by Facility Director.

a. The Chief of Staff convenes the PSB to investigate the matter, meet with the Practitioner if requested and make a report thereof to the MEB within fourteen (14) days after the effective date of the Summary Suspension.

b. Immediately upon the imposition of a Summary Suspension, the Service Chief or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.

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

(1) Significant deficiencies in clinical practice such as lack of diagnostic or treatment capability; multiple errors in prescribing, administering or documenting medications, inability to perform clinical procedures considered basic to the performance of one's occupation or performing procedures not included in one's clinical privileges in other than emergency situations;

(2) Patient neglect or abandonment;

(3) Mental health impairment sufficient to cause the individual to make judgment errors affecting patient safety, to behave inappropriately in the patient care environment or to provide unsafe patient care;

(4) Physical health impairment sufficient to cause the individual to provide unsafe patient care;

(5) Substance abuse when it affects the individual's ability to perform appropriately as a health care provide or in the patient care environment;

(6) Falsification of credentials;

(7) Falsification of medical records or prescriptions;

(8) Theft of drugs;

(9) Inappropriate prescription of drugs;

(10) Unethical behavior;

(11) Patient abuse, including mental, physical, sexual, and verbal abuse, and including any action or behavior that conflicts with a patient's rights identified in 38 USC 7462; intentional omission of care; willful violations of a patient's privacy; willful physical injury; or intimidation, harassment or ridicule of a patient;

(12) Falsification of research findings.

6. **Automatic Suspension of Privileges**: An Automatic Suspension occurs immediately, upon the occurrence of specific events.

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

(1) The Practitioner is being investigated, indicted or convicted of a misdemeanor or felony that could impact the quality and safety of patients.

(2) Failure on the part of any staff member to complete medical records in accordance with system policy will result in progressive disciplinary action to possible indefinite suspension.

(3) The Practitioner is being investigated for fraudulent use of the Government credit card.

(4) Failure to maintain the mandatory requirements for membership to the medical staff.

(5) Loss of a specific credential required for a specific privilege will result in the immediate loss of that specific privilege with 30 workdays to renew the credential. Failure to obtain the credential to perform that privilege after 30 days will result in a loss of that privilege until the provider is re-credentialed.

b. The Chief of Staff convenes the PSB to investigate the matter and make a report thereof to the MEB within fourteen (14) days after the effective date of the Automatic Suspension.

c. Immediately upon the occurrence of an Automatic Suspension, the Service Chief or the Chief of Staff provides alternate medical coverage for the patients of the suspended Practitioner.

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

7. **Actions Not Constituting Corrective Action**: The PSB will not be deemed to have made a proposal for an adverse recommendation or action, or to have made such a recommendation, or to have taken such an action, and the right to a Hearing will not have arisen, in any of the following circumstances:

a. The appointment of an ad hoc investigation committee;

b. The conduct of an investigation into any matter;

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

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

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

f. The issuance of a letter of warning, admonition, or reprimand;

g. Corrective counseling;

h. A recommendation that the Practitioner be directed to obtain retraining, additional training, or continuing education; or

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

8. Failure to maintain current licensure:

a. Expiration of all licensures or loss of any licensure for cause will result in immediate separation of employment according to VHA Handbook 5005/12, Part II, Chapter 3, dated 8/12/05, Handbook 5021, Part VI, and VHA Handbook 1100.19. Facility employees whose separations are approved by the facility Director, have the right to seek a post-separation or post-cancellation review of the action by the Network Director. The appointment of an individual who does not fully meet all statutory and regulatory requirements at the time of appointment will be cancelled immediately upon discovery of the disqualification.

b. Care of suspended individual's patients: Immediately upon the imposition of a suspension the appropriate Service Chief, or, in his/her absence, the Chief of Staff, shall assign to another individual, with appropriate clinical privileges, responsibility for care of the suspended individual's patients (both inpatients and outpatients). The wishes of the patient shall be

considered in the selection of a provider. It shall be the duty of the Chief of Staff and the Service Chief to cooperate with the Director in enforcing all suspensions.

ARTICLE X. FAIR HEARING AND APPELLATE REVIEW

1. **Reduction of Privileges:**

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

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

(2) A statement of the Practitioner‘s right to be represented by counsel or a representative of the individual’s choice, throughout the proceedings.

b. The Practitioner will be allowed to review all evidence not restricted by regulation or statute upon which proposed changes are based. Following that review, the Practitioner may respond in writing to the Chief of Staff’s written notice of intent. The Practitioner must submit a response within l0 workdays 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 l0 additional workdays except in extraordinary circumstances.

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

2. **Convening a Panel**: The facility Director must appoint a review panel of three unbiased professionals, within 5 workdays after receipt of the Practitioner's request for hearing. These three professionals will conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges. Any other review processes must be conducted on the basis of the record. The hearing will proceed as follows:

a. The Practitioner must be notified in writing of the date, time, and place of the hearing. The date of the hearing must not be less than 20 workdays and not more than 30 workdays from the date of notification letter.

b. During such hearing, the Practitioner has the right to:

(1) Be present throughout the evidentiary proceedings.

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

(3) Cross-examine witnesses.

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

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

4. The panel must complete the review and submit the report within 15 workdays from the date of the close of the hearing. Additional time may be allowed by the facility Director for extraordinary circumstances or cause.

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

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

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

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

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

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

f. Practitioner Rights:

(1) The Practitioner has the right to be present throughout the evidentiary proceedings, represented by counsel or a representative of Practitioner's choice, cross-examine witnesses, and to purchase a copy of the transcript or tape of the hearing.

(2) The panel will complete its review and submit its report within 15 workdays of the date of the hearing. Additional time may be allowed by the Director for extraordinary circumstances or cause. The panel's report, including findings and recommendations, will be forwarded to the Director, who has authority to accept, accept in part, modify, or reject the review panel's recommendations.

(3) The Director will issue a written decision within l0 workdays of the day of receipt of the panel's report. If the Practitioner's privileges are reduced, the written decision will indicate the reason(s) for the change.

(4) The Practitioner may submit a written appeal to the VISN Director within five workdays of receipt of the Director's decision.

(5) The VISN Director will provide a written decision based on the record within 20 workdays after receipt of the Practitioner's appeal. The decision of the VISN Director is not subject to further appeal.

(6) A Practitioner who does not request a review panel hearing but who disagrees with the Director's decision may submit a written appeal to the appropriate VISN Director within five workdays after receipt of the Director's decision.

(7) The review panel hearing defined in paragraph d will be the only hearing process conducted in connection with the reduction of privileges; any other review processes will be conducted on the basis of the record.

(8) 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.

5. **Revocation of Privileges**:

a. Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures.

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

(2) For probationary employees appointed under 38 U.S.C. 7401(1) and 38 U.S.C. 7405, the proposed revocation will be combined with probationary separation procedures, which constitutes an automatic revocation as contained in VA Handbook 5021 Employee/Management Relations.

b. Revocation procedures will be conducted in a timely fashion. If discharge, separation during probation, or termination of appointment is not proposed, revocation of clinical privileges may not occur. Even though a revocation of privileges requires removal from both employment and appointment to the medical staff, in extremely rare cases, there may be a credible reason to reassign the Practitioner to a position not requiring clinical privileges. Such an action may still result in reporting to the NPDB if the revocation and reassignment is for substandard care, professional incompetence, or professional misconduct. For example a surgeon's privileges for surgery may be revoked and the surgeon reassigned to a non-surgical area when doing so is beneficial to meeting other needs of the facility. Any recommendation by the MEB for the reduction, suspension, or revocation of clinical privileges, or for the suspension or revocation of Medical Staff membership, entitles the Practitioner to the rights set forth in Article X of these Bylaws.

6. **Reporting to the National Practitioner Data Bank**[2]:

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, U.S. Attorney) investigate the allegations, and deny, settle, or defend the case. Claims that are denied may subsequently go to litigation.

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

[2] Reference VHA Handbook 1100.17.

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

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

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

7. **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.

8. **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 U.S.C.7401(1) and 7405 may be terminated when this is determined to be in the best interest of VA in accordance with provisions of VHA Handbook 5021 Employee/Management Relations.

9. Where the actions of a licensed trainee warrant reporting, but did not result from gross negligence or willful professional misconduct, the attending is to be reported without mention of an involved trainee, but with a notification that the attending is being reported in a supervisory capacity. In circumstances where the Review Panel concludes that the payment of a claim was related to substandard care, professional incompetence, or professional misconduct resulting from gross negligence or willful professional misconduct on the part of a licensed trainee in a training or residency program, the trainee must be reported to the NPDB (the attending is not

reported). Unlicensed trainees are not to be reported. For further information, please refer to VHA Handbook 1100.17.

ARTICLE XI. RULES AND REGULATIONS

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

ARTICLE XII. AMENDMENTS

1. The Bylaws are reviewed at least every two years, revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws may be submitted in writing to the Chief of Staff by any member of the Medical Staff. Recommendations for change come directly from MEB. Changes to the Bylaws are amended, adopted and voted on by the Organized Medical Staff as a whole and then approved by the Director. The Bylaws are amended and adopted by two-thirds endorsement of the active medical staff. If a quorum is not present at a regular or called meeting of the Medical Staff, the Chief of Staff shall direct the MEB to act upon the proposed significant changes that have been published. A quorum of the MEB to act upon these changes is 2/3 of the voting membership of the committee. The document will then be sent to the Governing Council for action and to the Director. Upon approval, these changes will be adopted and made active.

2. The Executive Committee may provisionally adopt and the Director may provisionally approve urgent amendments to the Rules and Regulations that are deemed and documented as such, necessary for legal or regulatory compliance without prior notification to the medical staff. After adoption, these urgent amendments to the Rules and Regulations will be immediately communicated back to the Organized Medical Staff for retrospective review and moment on the provisional amendment. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Resolution and Management process noted in Article III, Section 3.05 should be followed.

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

4. All changes to the Bylaws require action by both the Organized Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.

5. Changes are effective when approved by the Director.

ARTICLE XIII. ADOPTION

These Bylaws shall be adopted upon recommendation of the voting-eligible medical staff at any regular or special meeting of the active Medical Staff at which a quorum is present or by a 2/3 vote of a quorum at a Medical Executive Board meeting, shall be recommended by the Governing Council, shall replace any previous Bylaws and shall become effective when approved by the Director.

If the voting members of the organized medical staff propose to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the Executive Committee. If the Executive Committee proposes to adopt a rule, regulation or policy or an amendment thereto, they must first communicate the proposal to the medical staff. When the Executive Committee adopts a policy or amendment thereto, it must communicate this to the medical staff.

Adopted by the Medical Staff of the VA Tennessee Valley Healthcare System, on March 27, 2015.

Recommended:

//s// 4/20/15

Roger C. Jones, M.D., FACP **Date**

Chief of Staff

Approved:

//s// 4/20/15

Juan A. Morales, RN, MSN **Date**

Health System Director