

## PREAMBLE and DEFINITIONS

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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 within the VA Nebraska-Western Iowa Health Care System, with administrative offices located in Omaha, Nebraska (hereinafter sometimes referred to as NWIHCS), hereby organizes itself for self-governance in conformity with the laws, regulations and policies governing the Department of Veterans Affairs, Veterans Health Administration (VHA), and the bylaws and rules hereinafter stated. These bylaws and rules are consistent with all laws and regulations governing the VHA, and they do not create any rights or liability not otherwise provided for in laws or VHA Regulations.

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

### Definitions

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

1. **Appointment:** As used in this document, the term Appointment refers to appointment to the Medical Staff. Both VA employees and contractors providing patient care services must receive appointments to the Medical Staff. Appointment is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority to provide independent medical, midlevel and/or patient care services at the facility.
2. **Associate Director:** The Associate Director fulfills the responsibilities of the Director as defined in these bylaw when serving in the capacity of Acting Facility Director.
3. **Associate Director for Patient Care Services:** The Associate Director for Patient Care Services 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 Chair of the Nurse Executive Counsel (NEC) and acts as full assistant to the Director in the efficient management of clinical and patient care services to eligible patients, the active maintenance of a credentialing and scope of practice system for relevant midlevel and certain allied health staff and in ensuring the ongoing education of the nursing staff.
4. **Associated/Allied Health Professionals:** Associated Health Professionals or Allied Health Professionals are those clinical professionals (other than doctors of allopathic, dental, and osteopathic medicine) who exercise independent judgment within the areas of their professional competence, and who are qualified to render direct or indirect professional care, either (a) independently but in association with, or (b) under the direction and supervision of, a practitioner who has been accorded privileges to provide such care at NWIHCS.
  - Associated Health Professionals include Podiatrists, Clinical Psychologists, Optometrists, Audiologists (PhD), and Speech Pathologists (PhD), and function under defined clinical privileges.
  - Allied Health Professionals include Pharmacists (PharmDs), Bacteriologists, Chemists, Dental Auxiliaries, Nurse Clinicians, Nurse Practitioners, Physician Assistants, Physiologists, Special Care Unit Nurses, and certain qualified Therapists (e.g., Occupational, Physical, Respiratory), and function under a defined scope of practice.

5. **Automatic Suspension of Privileges:** Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Reactivation must be endorsed by the Executive Committee of the Medical Staff and approved by the Director.
6. **Chief of Staff (COS):** The Chief of Staff is the president of the Medical Staff and Chair of the Executive Committee of the Medical Staff and acts as 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 practitioners, Midlevel Practitioners, and Associated/Allied health professionals. The Chief of Staff ensures the ongoing medical education of the medical staff.
7. **Community Based Outpatient Clinic (CBOC):** A health care site (in a fixed location) that is geographically distinct or separate from the parent medical facility, but whose oversight is assigned to a medical facility within NWIHCS. 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.
8. **Credentials Committee / Professional Standards Board (PSB):** the Credentials Committee acts on credentialing and clinical privileging matters of the Medical Staff, including review of Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE), making recommendation on such matters to the Executive Committee of the Medical Staff as defined in these bylaws. In its combined function as Professional Standards board (PSB), the Credentials Committee may also act and/or make recommendations to the Director regarding practitioner eligibility, qualifications, grade and rate of pay, as well as special advancement, promotion, separation, and other actions.
9. **Director (or Facility Director):** The Director is appointed by the Governing Body to act as its agent in the overall management of the Facility. The Director is assisted by the Chief of Staff (COS), the Associate Director (AD), the Associate Director for patient Care Services (AD-PCS), and the Executive Committee of the Medical Staff (XCOM).
10. **Ex Officio:** Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.
11. **Executive Committee of the Medical Staff (XCOM):** The committee empowered to act for the medical staff in the interval between meetings of the entire medical staff, subject to such limitations as contained in these bylaws.
12. **FPPE / OPPE:** Documented time-limited (FPPE) or periodic (OPPE) evaluations of each practitioner's clinical competence.
  - Focused Professional Practice Evaluation (FPPE) – The time limited evaluation of practitioner competence in performing a specific privileges. This process is implemented for 1) all initially requested privileges; 2) all modifications of privileges involving addition of a privilege; and 3) whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care.
  - Ongoing Professional Practice Evaluation (OPPE) – A documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise

or revoke existing privilege(s) prior to or at the end of the two-year license and privilege renewal cycle.

13. **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 purpose 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.
14. **Licensed Independent Practitioner (LIP):** The term Licensed Independent Practitioner (LIP) refers to any individual permitted by law and by NWIHCS to provide care and services, without direction or supervision, within the scope of the individual's unrestricted license and consistent with individually granted clinical privileges. In this organization, this includes Physicians and Dentists (post-graduate trainees [house officers] are not considered Licensed Independent Practitioners), other individuals who meet the criteria for independent practice, and who function under defined clinical privileges (e.g., Podiatrists, PhD Clinical Psychologists, Optometrists, PhD and AuD Audiologists, and PhD Speech pathologists) may, as determined by this organization, be considered Licensed Independent Practitioners.
15. **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.
16. **Medical Staff Year:** The period from October 1 through September 30.
17. **Medico-Administrative Officer:** A practitioner whose duties include certain responsibilities which 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 and include the supervision of professional activities of practitioners under his/her direction.
18. **Midlevel Practitioners:** Allied health professionals who are not Physicians or Dentists, but who function within a scope of practice under the direction and supervision of a Licensed Independent practitioner who has been accorded clinical privileges at NWIHCS to provide such care. As determined by this organization, Midlevel Practitioners may have prescriptive authority as allowed by Federal Regulations, and/or state of licensure statutes and regulations, under the supervision of a credentialed and privileged Licensed Independent Practitioner when required. Midlevel practitioners do not have admitting privileges. Midlevel Practitioners may initiate prescriptions for non-formulary drugs or prescribe controlled substances in accordance with state of licensure statutes and regulations.
19. **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.
20. **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.

21. **Primary Source Verification:** Documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be a letter, documented telephone contact, or secure electronic communication with the original source.
22. **Proctoring/Observing:** 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, or may not, be considered a reduction of privileges.
23. **Rules and Regulations:** Refers to the specific rules and regulations set forth that govern the Medical Staff. The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. Since they are a separate document from the Bylaws, the medical Staff Rules and Regulations can be reviewed and revised by the Executive Committee of the Medical Staff and without adoption by the medical staff as a whole. Such changes shall become effective when approved by the Director.
24. **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-off on care is delivered at the site of the patient by a licensed independent health care provider.
25. **Telehealth (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.
26. **VA Regulations:** The regulations set by Department of Veterans Affairs and made applicable to its entities in compliance with Federal laws (Example: Code of Federal Regulation (CFR) 38 7402).

## **ARTICLE I. NAME**

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The name of this organization shall be the Medical Staff of the Department of Veterans Affairs, Nebraska-Western Iowa Health Care System (VA NWIHCS).

## **ARTICLE II. PURPOSES OF THE MEDICAL STAFF**

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The purposes of the Medical Staff shall be to:

1. Assure that all patients receive safe, efficient, timely, and appropriate care that is subject to continuous quality improvement practices.
2. Assure that all patients being treated for the same health problem or with the same methods/procedures receive the same level or quality of care. Primary care programs shall assure continuity of care and minimize institutional care.
3. Establish and assure adherence to ethical standards of professional practice and conduct.
4. Develop and adhere to facility-specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.
5. Provide educational activities that relate to: care provided, findings of quality of care review activities, and expressed needs of caregivers and recipients of care.
6. Maintain a high level of professional performance of practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.
7. Assist the governing Body in developing and maintaining rules for Medical Staff governance and oversight.
8. Provide a medical perspective, as appropriate, to issues being considered by the Director and Governing Body.
9. Develop and implement performance and safety improvement activities in collaboration with the staff and assume a leadership role in improving organizational performance and patient safety.
10. Promote channels of communication so that medical and administrative matters may be discussed and problems resolved.
11. Establish organizational policy for patient care and treatment and implement professional guidelines from the under Secretary for Health, Veterans Health Administration.
12. Provide education and training, in affiliation with established programs, and assure that educational standards are maintained. Care shall be taken to appropriately document supervision of resident physicians and other trainees.

13. Initiate and maintain an active continuous quality improvement program addressing all aspects of medical practice. Daily operations shall be the subject of continuous quality improvement, as defined through organizational publications.
14. Coordinate and supervise the scope of practice of all Midlevel and appropriate Allied Health Professional staff so that their rights and practice goals are achieved and integrated expeditiously to benefit the care of patients. Each Midlevel and appropriate Allied Health practitioner should have a scope of practice statement as well as the means employed to coordinate and supervise their function with the medical staff.

## ARTICLE III. MEDICAL STAFF MEMBERSHIP

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### 3.01 Eligibility for Membership on the Medical Staff

1. **Membership:** Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent Physicians, Dentists, Podiatrists, Clinical Psychologists (PhD), Optometrists, Audiologists (PhD and AuD), and Speech Pathologists (PhD), who continuously meet the qualifications, standards, and requirements of VHA, this facility, and these bylaws.
2. Categories of the Medical Staff: Membership privileges and responsibility are based on the following categories:
  - a. Category I – Active Full-time Staff: Staff members who are actively practicing within, and employed by NWIHCS on a full-time permanent basis, and any who hold official administrative appointments. Members shall be assigned to a specific clinical service, and shall be eligible to vote and to serve on Medical Staff committees. Members shall take a leadership role in the oversight of the quality of care, treatment and service. Attendance at Organized Medical Staff meetings is required, unless formally excused.
  - b. Category II – Active Part-time Staff: Staff members who are actively practicing within and employed by NWIHCS on a less than full-time, permanent basis, but equal to or greater than a five-eighths (5/8) basis.\*\* Members shall be assigned to a specific clinical service, and shall be eligible to vote and to serve on Medical Staff committees. Attendance at Organized Medical Staff meetings is required, unless formally excused.
  - c. Category III – Affiliated Part-time Staff: Staff members who are actively practicing within and employed by NWIHCS on a less than five-eighths (5/8), permanent basis. Members shall be assigned to a specific clinical service and may serve on Medical Staff committees. Members are not eligible to vote. Attendance at Organized Medical Staff meetings is recommended.
  - d. Category IV – Associate Staff: Staff members practicing within, and employed by NWIHCS through a non-permanent status such as Fee Basis, Contract\*\*, Consultant, Courtesy, etc. Members shall be assigned to a specific clinical service and may serve on Medical Staff committees. Members are not eligible to vote. Attendance at Organized Medical Staff meetings is recommended.

**NOTE:** In the event an individual maintains a combination of VA employment at five-eighths (5/8) or more, and also Contract reimbursement status, that individual shall be eligible to vote, but shall be expected to excuse him/herself from voting on issues where a potential conflict of interest is evident.

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.

### **3.02 Qualifications for Medical Staff Membership and Clinical Privileges**

1. Criteria for Clinical Privileges: To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 3.01 must submit evidence as listed below. Applicants not meeting these requirements will not be considered. This determination of ineligibility is not considered a denial:
  - a. Active, current, full and unrestricted license to practice individual's profession in a state, territory or commonwealth of the United States or the District of Columbia, as required by VA employment and utilization policies and procedures.
  - b. Education applicable to individual Medical Staff members as defined, for example holding a Doctoral level degree in Medicine, Osteopathic Medicine, or Dentistry from a college or university approved by its recognized accrediting body.
  - c. Relevant training and/or experience consistent with the individual's professional assignment and the privileges for which he/she is applying. This may include any internship, residencies, fellowships, board certification, and other specialty training.
  - d. Current competence, consistent with the individual's assignment and the privileges for which he/she is applying.
  - e. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges granted.
  - f. Complete information consistent with requirements for application and clinical privileges as defined in Articles VI or VII or of these Bylaws for a position for which the facility has a patient care need, and adequate facilities, support services and staff.
  - g. Satisfactory findings relative to previous professional competence and professional conduct.
  - h. English language proficiency.
  - i. Current professional liability insurance as required by Federal and VA acquisition regulations for those individuals providing service under contract.
  - j. A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g., driver's license or passport).
2. Clinical Privileges and Scope of Practice: While only Licensed Independent Practitioners may function with defined clinical privileges, not all Licensed Independent Practitioners are permitted by this 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 shall be credentialed and privileged to practice independently, :
    - i) Physicians
    - ii) Dentists
  - b. The following Practitioners shall 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:
    - i) Podiatrists
    - ii) Clinical Psychologists (PhD)



- iii) Optometrists
  - iv) Audiologists (PhD or AuD)
  - v) Speech Pathologists (PhD)
- c. The following Midlevel Practitioners shall be credentialed and shall practice under a Scope of Practice with appropriate physician supervision:
- i) Physician Assistants
  - ii) Advanced Practice Registered Nurses (APRN)
  - iii) Certified Registered Nurse Anesthetists (CRNA)
4. 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.

### 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 the VA. Acceptable behavior includes the following:
- a. Being on duty and available as scheduled;
  - b. 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;
  - c. Not discriminating on the basis of race, age, color, gender, religion, sexual orientation, national origin, politics, marital status, or disability in any employment matter or in providing benefits under any law administered by the VA;
  - d. Not making a governmental decision outside of official channels;
  - e. Not taking any action that impedes government efficiency and economy, affects one's impartiality, or otherwise lowers public confidence in the Federal Government; and
  - f. 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: NWHCS recognizes that the manner in which its Practitioners interact with others can significantly impact patient care. NWHCS strongly urges its providers to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high

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

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

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

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

### 3.04 CONFLICT RESOLUTION AND MANAGEMENT

Conflict management is the process of planning to avoid conflict when possible and manage to resolve such conflict quickly and efficiently when it occurs. This 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. For additional information, please refer to VA Memorandum on *Alternative Dispute Resolution for Workplace Disputes* (February 8, 2007), VA Directive 5978, *Alternative Dispute Resolution* (February 23, 2000, and VA Handbook 5978.1, *Alternative Dispute Resolution Program*: Central Office (December 11, 2007).

## ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

#### **4.01 Leaders**

1. Composition:
  - a. Chief of Staff.

The Chief of Staff shall be the only officer of the Organized Medical Staff and shall perform duties as outlined in Section 4.02 below. Selection, appointment and removal shall be in accordance with Federal statute and VA regulations currently extant and contained in the U.S. Code and appropriate VA Manuals, Directives, and Policies. Nomination or initiation of removal action shall originate with the Director after consultation with or petition by Clinical Service Chiefs and/or a significant number of active Medical Staff members. Final authority resides at the network or headquarters level of VHA.

#### **4.02 Duties of Officer – Chief of Staff**

The Chief of Staff shall serve as the chief administrative officer of the Medical Staff according to Department of Veterans Affairs regulations to:

- a. Act in coordination and cooperation with the Director in all matters of mutual concern within the Health Care System.
- b. Call, preside at, and be responsible for the agenda of all general meetings of the medical Staff.
- c. Serve as chairman of the Executive Committee of the Medical Staff.
- d. Be responsible for the enforcement of Medical Staff bylaws, Rules and Regulations in collaboration with the chiefs of the clinical departments and shall implement sanctions and other corrective action when authorized.
- e. Appoint committee members to all standing, special and multidisciplinary Medical Staff committees except the Executive Committee of the Medical Staff.
- f. Represent the views, policies, needs and grievances of the medical Staff to the Director.
- g. Receive and interpret the policies of the Director to the Medical Staff, and report to the Director on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.
- h. In cooperation with chiefs of clinical departments and other organizational elements, develop, implement, supervise and evaluate programs in performance improvement, credentialing, continuing education, and utilization review.
- i. Participate in the selection and appointment of chiefs of clinical departments.

#### **4.03 Leadership**

1. 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 patients care, treatment, and services including evaluating and improving the quality and safety of patient care services.

#### **4.04 Clinical Services and Sections**

##### **1. Characteristics**

- a. The Medical Staff shall be departmentalized. Each Clinical Service shall be organized as a separate but integral component of the Medical Staff and shall have a Service Chief who shall be responsible for the overall supervision of the clinical work within the Service, according to Department of Veterans Affairs regulations. Clinical Services established at NWIHCS are those authorized by the Department of Veterans Affairs and shall include the following:
  - Medicine
  - Surgery
  - Mental Health and Behavioral Science
  - Radiology
  - Pathology and Laboratory Medicine
- b. Large Clinical Services, or those that incorporate multiple specialties/subspecialties, each with an independent examining board authorized by the American Board of Medical Specialties, may be further comprised of subordinate divisions that are formally designated as Sections. Each Clinical Section shall be organized as a specialty subdivision within each department, shall be directly responsible to the department within which it functions, and may have a Section Chief designated according to Department of Veterans Affairs regulations, who may exercise such authority as delegated to him/her by the Service Chief.
- c. Clinical Services shall hold service-level meetings at least quarterly.

**2. Functions:**

- a. Provide for quality and safety of the care, treatment, and services provided by the Service. This requires ongoing monitoring 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, on a quarterly basis.
- 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 privileges 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 the Executive Committee of the Medical Staff.

**3. Selection and Appointment of Service Chiefs:**

Service Chiefs are appointed by the Director based upon the recommendation of the Chief of Staff.

**4. Duties and Responsibilities of Service Chiefs:**

The Service Chief is administratively responsible for the operation of the Service and its clinical and research efforts, as appropriate. In addition to duties listed below, the Service Chief is responsible for assuring the Service performs according to applicable VHA performance standards. 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.

**5. Duties and Responsibilities of Section Chiefs:**

The duties of Section Chiefs, within the framework of VA Regulations, shall be to:

- a. Be a member of the Active Staff and a member of the section which he/she is to head; be qualified by training, experience, interest and demonstrated current ability in the clinical area covered by the section; be certified by a relevant American Specialty Board or meet equivalency requirement specified by the Medical Staff; and be willing and able to discharge the administrative responsibilities of his/her office. The chief of the department shall select the Section Chief and his/her term of office shall be continuous within the framework of Department of Veterans Affairs regulations.
- b. Account to his/her Department Chief for the effective operation of his/her section and for his/her section's discharge of all tasks delegated to it.
- c. Collaborate with his/her Department Chief in the organization-wide program to assess and improve the quality of care and services provided.
- d. Exercise general supervision over all clinical work performed within his/her section and of the qualifications and competence of individuals within the section who are not licensed independent practitioners but who provide patient care or services.
- e. Submit reports and recommendations to the Department Chief regarding the clinical privileges to be exercised within the section by members of or applicants to the Medical Staff and the qualifications required therefore, and the specified services to be provided by Associated Health Personnel.
- f. Act as presiding officer at all section meetings.
- g. Submit reports to the Department Chief on the activities of the section as required.
- h. Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Department Chief or other appropriate authority, including those responsibilities listed in the Bylaws and Rules and Regulations of the Medical Staff.

## ARTICLE V. MEDICAL STAFF COMMITTEES

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### 5.01 General

1. Committees are either standing or special.
2. All committee members, regardless of whether they are members of the Medical Staff, shall be eligible to vote on committee matters unless otherwise set forth in these Bylaws.
3. The presence of fifty percent plus one (50% + 1) of a committee's members shall constitute a quorum.
4. The members of all standing committees, other than the Executive Committee of the Medical Staff, shall be appointed by the Chief of Staff subject to approval by the Executive Committee of the Medical Staff, unless otherwise stated in these Bylaws.
5. Unless otherwise set forth in these Bylaws, the Chair of each committee shall be appointed by the Chief of Staff.
6. Robert's Rules of Order shall govern all committee meetings.

### 5.02 Executive Committee of the Medical Staff

1. Characteristics: The members of the Executive Committee of the Medical Staff shall be:
  - a. Chief of Staff, Chairperson, voting.
  - b. Clinical Service Chiefs, voting.
  - c. Practitioners appointed through the medical staff process, voting.
  - d. Director, or designee, ex-officio, non-voting.
  - e. Nurse Executive, ex-officio, non-voting.
  - f. 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. For example, a Physician Assistant may be called to be present when an action affecting another Physician Assistant is being considered. Any member of the Medical Staff (with or without vote) is eligible for consideration.
  - g. A majority of the voting members must be fully licensed physicians of medicine or osteopathy.
2. Functions of the Executive Committee of the Medical Staff: The Executive Committee of the Medical Staff:
  - a. Acts on behalf of the Medical Staff between Medical Staff meetings.
  - 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

- c. scope of practice requested; to address the scope and quality of services provided within the facility.
- d. Acts to ensure effective communications between the Medical Staff and the Director.
- e. Makes recommendations directly to the Director regarding the:
  - i) Organization, membership (to include termination), structure, and function of the Medical Staff.
  - ii) Process used to review credentials and delineate privileges for the medical staff.
  - iii) Delineation of privileges for each Practitioner credentialed.
- f. 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.
- g. Oversees process in place for instances of "for-cause" concerning a medical staff member's competency to perform requested privileges.
- h. Oversees process by which membership on the medical staff may be terminated consistent with applicable laws and VA regulations.
- i. Oversees process for fair-hearing procedures consistent with approved VA mechanisms.
- j. Monitors medical staff ethics and self-governance actions.
- k. Advises facility leadership and coordinates activities regarding clinical policies, clinical staff recommendations, and accountability for patient care.
- l. 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.
- m. 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.
- n. Acts upon recommendations from the Credentials Committee.
- o. 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 Provider. 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 care facility Director. Boards may be conducted at



other VA healthcare facilities.

- p. Provides oversight and guidance for fee basis/contractual services.
- q. Annually reviews and makes recommendations for approval of the Service-specific privilege lists.

3. Meetings:

- a. Regular Meetings: Regular meetings of the Executive Committee of the Medical Staff shall be held at least monthly. 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 Executive Committee of the Medical Staff 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 automatically entitle the attendee to vote on any matter before the Executive Committee of the Medical Staff.
- b. Emergency Meetings: Emergency meetings of the Executive Committee of the Medical Staff may be called by the Chief of Staff to address any issue which requires action of the Committee prior to a regular meeting. The agenda for any emergency meetings shall be limited to the specific issue for which the meeting was called, and no other business may be taken up at an emergency meeting. In the event that the Chief of Staff is not available to call an emergency meeting of the Executive Committee of the Medical staff, the Director as the Governing Body or Acting chief of Staff, acting for the Chief of Staff, may call an emergency meeting of the Committee.
- c. Meeting Notice: All Executive Committee of the Medical Staff members shall be provided 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 Executive Committee of the Medical Staff. The Chair shall establish the agenda for all meetings, and a written agenda shall be prepared and distributed prior to committee meetings.
- e. Quorum: A quorum for the conduct of business at any regular or emergency meetings of the Executive Committee of the Medical Staff shall be fifty percent plus one (50% + 1) of the voting members of the committee, unless otherwise provided in these Bylaws. Action may be taken by majority vote at any meeting at which a quorum is present. 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 Executive Committee of the Medical Staff, 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 Executive Committee of the Medical Staff at which action is taken shall be responsible

for communicating such action to any person who is directly affected by it.

## 5.03 Committees of the Medical Staff

1. The following Standing Committees are hereby established for the purpose of (a) evaluating and improving the quality of health care rendered; (b) reducing morbidity or mortality from any cause or condition; (c) establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds; (d) reviewing the professional qualifications of applicants for medical staff membership; (e) reviewing the activities of the Medical Staff and Mid-Level and Allied health Practitioners; (f) reporting variances to accepted standards of clinical performance by, and in some cases to, individual Practitioners; and (g) for such additional purposes as may be set forth in the charges to each committee:
2. Information Flow to Executive Committee of the Medical Staff: All Medical Staff Committees, shall submit minutes of all meetings to the Executive Committee of the Medical Staff in a timely fashion after the minutes are approved and shall submit such other reports and documents as required and/or requested by the Executive Committee of the Medical Staff. Supplemental reports from additional committees may also be deemed by the Executive Committee of the Medical Staff to be appropriate.
  - a. Patient Safety Committee
    - i) Charge: (a) participate in developing and implementing an integrated interdisciplinary Facility-wide program to monitor the quality and safety of patient care and to promote an effective and efficient utilization of manpower, facilities and services; (b) facilitate mechanisms for correction of problems identified; (c) review the performance monitoring activities of committees reporting to Quality Management; (d) assist all Facility Services and Departments in identifying and evaluating problems in ancillary service utilization and encourage solutions which enhance quality of care; (e) fulfill the review requirements of The Joint Commission, and other external reviewing organization; (f) report to the Chief of Staff, the Executive Committee of the Medical Staff, and the Facility Director pertinent issues concerning the quality control and performance improvement efforts.
  - b. Credentials Committee:
    - i) Charge: (a) Review applications for appointment to the Medical Staff referred to it by the Service Chiefs; (b) review all recommendations of the Chief of Staff and Service Chiefs; (c) conduct personal interviews of candidates at its discretion; (d) conduct a personal interview with the Chief of Staff and/or Service Chief in all instances of disapproval of an application by the Chief of Staff and/or Service Chief or both. In the event of the intent of the Committee to recommend disapproval, personal interviews shall be held with the Chief of Staff and Service Chief, if appropriate, and with the candidate after written notification to the candidate of the intended disapproval. (e) Between recredentialing cycles, review the status and appropriateness of clinical privileges when cases are referred by the Chief of Staff or Service Chief. (f) At the request of the Chief of Staff, review new/proposed changes to delineation of clinical privileges form(s);

- (g) Recommend appropriate action to the Executive Committee of the Medical Staff; (h) Act as Medical Staff Professional Standards Board in matters of practitioner compensation.
- c. Pharmacy and Therapeutics Committee:
  - i) Charge: (a) Recommend professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to pharmaceuticals; (b) recommend programs designed to meet the needs of the professional staff of the Facility for complete current information on matters related to pharmaceuticals and current pharmaceutical practices.
- d. Infection Control Committee:
  - i) Charge: (a) Define, survey, correlate, review, evaluate, revise and institute whatever recommendations are necessary in order to prevent, contain, investigate, and control nosocomial infections and other infectious diseases among patients and personnel; (b) submit committee minutes to the Executive Committee of the Medical Staff monthly; and (c) report a summary of its activities to the Executive Committee of the Medical Staff annually.
- e. Medical Record Committee:
  - i) Charge: The Medical Record Committee is responsible for the assessment of the adequacy of medical record documentation by clinical staff with regard to completeness, timeliness, and accuracy. The Medical Record Committee will approve all forms, note titles and shared electronic templates used in the Medical Record.
- f. Research and Development Committee:
  - i) Charge: (a) Advise and assist in providing oversight, planning, and execution of the NWIHCS research program; (b) assist in maintaining high standards throughout the R&D Program, ensuring scientific and ethical quality of VA research projects, protection of human subjects in research, safety of personnel engaged in research, welfare of laboratory animals, security of VA data, and security of VA research laboratories.
- g. Cancer Committee:
  - Charge: The Cancer Program success depends on an effective, multidisciplinary Cancer Committee. The cancer committee is responsible for goal setting, planning, initiating, implementing, evaluating and improving all cancer-related activities in the program.

#### 5.05 Establishment of Committees

1. The Executive Committee of the Medical Staff 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 Executive Committee of the Medical Staff 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

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1. Regular Meetings: Regular meetings of the Medical Staff shall be held at least annually. A record of attendance shall be kept.
2. Special Meetings: Special meetings of the Medical Staff may be called at any time by the Chief of Staff or at the request of the Director or the Executive Committee of the Medical Staff. At any such meetings, 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, at either a regular meeting or a special meeting, not less than twenty-five (25) percent plus one (25% plus one) of the total membership of the medical staff entitled to vote shall constitute a quorum.

## ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

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### 7.01 General Provisions

1. Independent Entity: The Nebraska-Western Iowa Health Care System (NWIHCS) is an independent entity, granting privileges to the medical staff through the Executive Committee of the Medical Staff (XCOM) and Governing Body as defined in these Bylaws. Credentialing and privileging are performed prior to initial appointment. Medical Staff, Midlevel Practitioner, and Allied Health Practitioner reappointments may not exceed two (2) years, minus one day from the date of last appointment or reappointment date. Medical Staff and Midlevel and Allied Health Practitioners must practice under their privileges or scope of practice.
2. Credentials Review: All Licensed Independent Practitioners (LIP), and all Midlevel and Allied health practitioners who hold clinical privileges or scope of practice shall 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 Midlevel and Allied health practitioners shall 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 two (2) years.
3. Deployment/Activation Status:
  - a. When a member of the medical staff has been deployed to active duty, upon notification, the privileges shall be placed in a "Deployment/Activation Status" and the credentialing file shall remain active. Upon return of the Practitioner from active duty, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Practitioner shall update the credentialing file to current status.
  - b. After verification of the updated information is documented, the information shall be referred to the Practitioner's Service Chief, then forwarded to XCOM for recommendation to restore privileges to active, current status, based on evidence of current competence. Special circumstances may warrant the Service Chief and XCOM to put an FPPE in place to support current competence. The Director has final approval for restoring privileges to active and current status.
  - b. 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.
  - c. 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, at least on a short-term basis. These providers may be returned to a pay status, but a determination may be made as to whether they may immediately return to direct patient care.
3. 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.

4. Initial Focused Professional Practice Evaluation (FPPE):

- 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 requests a new privilege. The performance monitoring process is defined by each Service and must include:
  - i) Criteria for conducting performance monitoring
  - ii) Method for establishing a monitoring plan specific to the requested privilege
  - iii) Method for determining the duration of the performance monitoring
  - iv) Circumstances under which monitoring by an external source is required.
- b. An initial Medical Staff appointment does not equate to HR employment. FPPE does not equate to a probationary period. The FPPE is separate and distinct from the HR probationary review listed below:
  - i) Initial and certain other appointments made under 38 U.S.C. 7401(l), 7401(3), 5 U.S.C. 3301 are probationary. During the probationary period, professional competence, performance, and conduct will be closely evaluated under applicable VA policies, procedures, and regulations.
  - ii) If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply the same processes to the evaluation of individuals employed under provision of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.

6. Ongoing Professional Practice Evaluation (OPPE):

- a. The ongoing 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 ongoing 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 ongoing monitoring process. Data must be practitioner specific, reliable, easily retrievable, timely, defensible, comparable, and risk adjusted where appropriate.
  - i) 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 at least every six (6) months. 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.
  - iii) 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 38 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 ongoing monitoring program, and compared to pre-defined facility triggers or de-identified quality management data.

- iv) 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.
- v) XCOM 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 to the Director for the granting of privileges. This deliberation must be clearly documented in the XCOM minutes.
- vi) 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 this consideration must be documented.

## 7.02 Application Procedures

1. Completed Application: Applicants for Medical Staff appointment to the Medical Staff must submit a complete application utilizing the electronic Web-based VetPro credentialing database system, as required by VHA Handbook 1100.19 and all VHA related guidelines. The applicant is bound to be forthcoming, honest and truthful. 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:
    - i) Active Current, Full, and Unrestricted License: In instances where Practitioners have multiple licenses, the same primary source verification process must be followed for all licenses. Limitations defined by state licensing authorities must also be considered when determining whether licensure requirements are met.
    - ii) Education.
    - iii) Relevant training and/or experience.
    - iv) Current professional competence and conduct.
    - v) Physical and Mental Health status.
    - vi) English language proficiency.
    - vii) Professional liability insurance (contractors only).
    - viii) BLS certification approved by the American Heart Association.
    - ix) To qualify for moderate sedation and airway management privileges, the Practitioner shall have specific, approved clinical privileges, shall be ACLS certified (or equivalent), and shall acknowledge that they have received a copy of "The Sedation and Analgesia by Non-Anesthesia Providers" policy and agree to the guidelines outlined in the policy.
  - b. U.S. Citizenship: Applicants must be citizens of the United States. When it is not possible to recruit qualified citizens, Practitioner otherwise eligible for Medical Staff appointment who are not citizens shall 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 just completing a residency, one reference must come from the residency training program director. The Facility Director may require additional information.
  - d. Previous Employment: A list of all health care institutions or other organizations where the Practitioner is/has been appointed, utilized or employed (held a professional appointment), including:
    - i) Name of health care institution or practice.
    - ii) Term of appointment or employment and reason for departure.
      - i) 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:
    - i) Status, either current or inactive.
    - ii) Any previously successful or currently pending challenges to, or the voluntary relinquishment of, all of the Practitioner's DEA/CDS registrations.
  - 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: Detailed status (Open, Pending, Closed, Dismissed, etc.) of all claims made against the Practitioner in the practice of any health occupation, including dismissals, final judgments or settlements.
  - 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 shall obtain primary source verification of:
- a. A minimum of four (4) references for initial credentialing, and two (2) for recredentialing, from individuals able to provide authoritative information regarding information as described in Article III, Section 2a of these Bylaws.
  - 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 Educational Commission for Foreign Medical Graduates (ECFMG) 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 shall be accomplished through the Federation of State Medical Boards (FSMB) Physician Data Center. This screening shall report all licenses known to FSMB ever held by the physician. If the screening 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. Regardless of case outcome, this includes all malpractice litigations, judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the practitioner to provide all pertinent information may be grounds for disciplinary action or decision not to appoint or reappoint.
  - k. The applicant's agreement to provide continuous care and to accept the professional obligations defined in these Medical Staff Bylaws, Rules and Regulations for NWIHC.
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 with 30 days of the request to the applicant may serve as a basis for denial of employment or appointment consideration.
  5. VetPro Required: All health care providers must submit credentialing information into the VetPro credentialing database system as required by VHA policy.

### 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 all Service criteria for clinical privileges are met.
2. CMO Review: In certain circumstances, 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 XCOM, 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 shall 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. Medical Staff Credentials Committee recommends to XCOM any Medical Staff appointment, based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
4. XCOM recommends to the Director any 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 thirty (30) work days of receipt of a fully complete application, including all required verifications, references and recommendations from the appropriate Service Chief and XCOM.
6. Applicant Informed of Status: Candidates for appointment who have submitted complete applications as defined by these Bylaws shall receive written notice of appointment or non-appointment, or return of the application because of inadequate information.

#### 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 (a) at time of initial appointment with privileges, (b) at the time of request for additional privileges, or (c) in case of a "for cause" event requiring a focused review.

- a. A 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, charts reviews, etc., and should be discussed with the Practitioner by the Service Chief.
- b. A FPPE at the time of request for additional privileges will be set by the Service Chief, and will cover a period of time, a number of procedures, and/or chart review.
- c. A FPPE initiated by a "for cause" event will be set by the Service Chief. FPPE for cause, where there is concern regarding competence and the care being rendered to patients, may require direct supervision and appropriate action on privileges, i.e., summary suspension.
- d. The FPPE monitoring process will clearly define and include the following:
  - i) Criteria for conducting the FPPE;
  - ii) Method for monitoring for specifics of requested privilege;
  - iii) Statement of the "triggers" for which a "for cause" FPPE is required;
  - iv) Measures necessary to resolve performance issues which will be consistently implemented.
- e. Information resulting from the FPPE process will be integrated into the Service specific performance improvement program (non-title 38 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 Practitioner being evaluated during the FPPE process, one or more of the following may occur at the discretion of the Service Chief:
  - i) Extension of FPPE review period;
  - ii) Modification of FPPE criteria;
  - iii) Privileges (initial or additional) may not be maintained (appropriate due process will be afforded to the Practitioner); or
  - ii) Termination of existing privileges (appropriate due process will be afforded to the Practitioner and will be appropriately terminated and reported).

#### 7.05 Local/VISN-Level Compensation Panels

Local VISN-level Compensation Panels recommend the appropriate pay table, tier level and market pay amount for individual Medical Staff members, as outlined in VA Handbook 5007, Part 1X/21. Appointment actions recommended by the Professional Standards Board require a separate review for a pay recommendation by the appropriate Compensation Panel.

## ARTICLE VIII. CLINICAL PRIVILEGES

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### 8.01 General Provisions

1. Clinical privileges are granted for a period of not more than two (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 requirements
  - c. For initial and reappointment, all time-limited credentials, including peer appraisals, must be current within 180 days of submission of the application. The term "current" applies to the timeliness of the verification and use for the credentialing and privileging process. If the delay between the candidate's application and appointment, reappointment or reporting for duty is greater than 180 calendar days, the candidate must update all time-limited credentials and information, including but not limited to licensure, current competence, and supplemental questions. The updated information must be verified prior to consideration by the Executive Committee of the Medical Staff. The verification date of a time-limited credential cannot be more than 120 days prior to the effective date of the privileges (VHA Handbook 1100.19, page 7).
3. A Practitioner may request modification or accretion of existing clinical privileges by submitting to the Service Chief a formal request for the desired change(s) with full documentation to support the change.
4. Associated Health and Midlevel 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. 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. Telehealth/Telemedicine: All Practitioners involved in the provision of telemedicine are subject to all existing requirements for credentialing and privileging, as identified in VHA Handbook 1100.19, Credentialing and Privileging, and related VISN policies.
10. 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.

## **8.02 Process and Requirement for Requesting Clinical Privileges**

1. Burden of Proof: When additional information is needed, the Practitioner requesting clinical privileges must furnish all information and other supporting documents needed for a proper evaluation of qualifications, professional competence, conduct, and ethics. The information must be complete, accurate, and verifiable. If questions arise, the requesting Practitioner is responsible for furnishing information to clarify concerns or issues on qualifications. Failure to provide necessary information within 30 days of request may result in denial of clinical privileges.
2. Requests in Writing: All requests for clinical privileges must be made in writing by the Practitioner and include a statement of the specific privileges being requested in a format approved by the Medical Staff.
3. Credentialing Application: the Practitioner applying for initial clinical privileges must submit a complete application for privileges that includes:
  - a. Complete appointment information as outlined in Section 2 of Article VI;
  - b. Application for clinical privileges as outline in this Article;
  - c. Evidence of professional training and experience in support of privileges requested;
  - d. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Executive Committee of the Medical Staff.
  - e. A statement of the current status of all licenses and certifications held.
  - f. A description of any and all (1) sanctions, including those by a hospital, state licensing agency or any other professional health care organization/professional organization/society; (2) voluntary or involuntary relinquishment of licensure or registration; (3) malpractice claims, suits or settlements (e.g. final judgment or settlements); and (4) reduction or loss of privileges at any other hospital within 15 days of the adverse action.
  - g. Names of other hospitals at which privileges are held and requests for copies of current privileges held.
  - h. Names and addresses of references qualified to provide authoritative information regarding training, experience, competence, health status, and fulfillment of obligations as a Medical Staff member within the privileges requested.

- i. Evidence of successful completion of an approved BLS program meeting the criteria of the American Heart Association.
4. Bylaws Receipt and Pledge: Prior to the granting of clinical privileges, Medical Staff members or applicants must pledge to provide for continuous care of their patients and agree to abide by the professional obligations in accordance with the Bylaws and Rules.
5. Moderate Sedation and Airway Management: To qualify for moderate sedation and airway management privileges, the Practitioner must have specific, approved clinical privileges and acknowledge that he/she has received a copy of Sedation and Analgesia by Non-Anesthesia Providers policy and agree to the guidelines outlined in the policy.

#### 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

1. Application: The Practitioner applying for renewal of clinical privileges must submit the following information:
  - a. An application for clinical privileges as outlined in Section 2 of this Article. This includes submission of the electronic recredentialing application through VetPro. Since practice, techniques, and facility missions change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur over time. Practitioners are encouraged to consider carefully and discuss the appropriateness of specific privileges with the appropriate Service Chief prior to formal submission of privilege requests.
  - b. Supporting documentation of professional training and/or experience not previously submitted.
  - c. A statement of the Practitioner's physical and mental health status as it relates to Practitioner's ability to function within privileges. This must be confirmed by a physician acceptable to the Organized Medical Staff. Reasonable evidence of health status may be required by the Executive Committee of the Medical Staff.
  - d. 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 (OPPE) monitoring and FPPE;
  - h. Continuous education to meet any local requirements for privileges requested;
  - i. Board certifications, if applicable;
  - j. Quality of care information.

#### 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, etc.
3. Current NPDB-HIPDB PDS Registration prior to rendering a decision.
3. A modification or enhancement of, or addition to, existing clinical privileges requires the approval of the Executive Committee of the Medical Staff, followed by the Director's approval.

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

- i) Medical/Clinical knowledge (education competency);
  - ii) Interpersonal and Communication skills (documentation; patient satisfaction);
  - iii) Professionalism (personal qualities);
  - iv) Patient Care (clinical competency);
  - v) Practice-based Learning & Improvement (research and development); and
  - iii) System-based Practice (access to care).
- b. Recommendation for clinical privileges subsequent to those granted initially are based on reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment, clinical and/or technical skills and quality of care, including results of monitoring and evaluation activities (such as surgical case review, drug usage evaluation, medical record review, blood usage review, medication use review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities, and OPPE.
3. The Executive Committee of the Medical Staff (XCOM) recommends to the Facility Director the granting of clinical privileges, based on each applicant successfully meeting the requirements for clinical privileges as specified in these Bylaws. The Credentials Committee can make the initial review and recommendation but this information must be reviewed and approved by the Executive Committee of the Medical Staff.
  4. Clinical privileges are acted upon by the Director within thirty (30) calendar days of receipt of the recommendation by the Executive Committee of the Medical Staff to appoint. All actions must be verified with an original signature.
  5. Originals of approved clinical privileges are placed in the individual Practitioner's Credentialing and Privileging File. A copy of approved privileges are given to the Practitioner and are readily available to appropriate staff for comparison with Practitioner procedural and prescribing practices.
  5. Review and approval of the scope of practice and prescriptive authority for Midlevel and Associated health practitioners is the responsibility of the Midlevel Providers Professional Standards Board or the Nurse Professional Standards Board, as appropriate.

#### 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 45 calendar days) by the Director or Acting Director on the recommendation of the Chief of Staff.
  - a. Temporary privileges are based on verification of the following:
    - i) One, active, current, unrestricted license with no previous or pending actions.
    - ii) 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.
    - iii) Current comparable clinical privileges at another institution.
    - iv) Response from NPDB-HIPDB PDS registration with no match.



- v) Response from FSMB with no reports.
- vi) No current or previously successful challenges to licensure.
- vii) No history of involuntary termination of medical staff membership at another organization.
- viii) No voluntary limitation, reduction, denial, or loss of clinical privileges.
- ix) No final judgment adverse to the applicant in a professional liability action.
- b. A completed application must be submitted within three (3) calendar days of temporary privileges being granted and credentialing completed.

2. Expedited Process:

- a. The Practitioner must submit a completed application through VetPro.
- b. The Facility:
  - i) Verifies education and training;
  - ii) Verifies one active, current, unrestricted license from a State, Territory, or Commonwealth of the United States or the District of Columbia;
  - iii) Receives confirmation on the declaration of health, by a physician acceptable to the facility, of the applicant's physical and mental capability to fulfill the requirements of the clinical privileges being sought;
  - iv) Queries licensure history through the Federation of State Medical Boards (FSMB) Physician Data Center and receives a response with no report documented;
  - v) Receives confirmation from two (2) peer references who are knowledgeable of and confirm the physician's competence, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges, or who would have reason to know the individual's professional qualifications;
  - vi) Verifies current comparable privilege(s) held in another institution;
  - vii) Receives a response from NPDB-HIPDB PDS registration with no match;
  - viii) Verifies that there are no current or previously successful challenges to licensure;
  - ix) Verifies that there is no history of involuntary termination of medical staff membership at another organization;
  - x) Verifies that there is no history of involuntary limitation, reduction, denial or loss of clinical privileges; and
  - xi) Verifies that there is no history of final judgment(s) adverse to the applicant in a professional liability action.
- c. At least two voting members of the Credentials Committee must recommend appointment to the Medical Staff.

- d. The recommendation by the delegated subcommittee of the Executive Committee of the Medical Staff (XCOM) must be acted upon by the Facility Director.
  - e. Full credentialing must be completed within sixty (60) calendar days of the date of the Director's signature and presented to the Executive Committee of the Medical Staff (XCOM) for ratification.
3. Emergency Care: Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm. Once imminent danger has passed, the care of the patient should be transferred as appropriate. Emergency care may also be provided by properly supervised residents of the facility's affiliated residency training programs.
4. Disaster Privileges: As described in the Facility's Emergency Management Plan:
- a. In the event of the implementation of the organization-wide disaster management plan, Disaster Privileges for additional non-NWI providers may be approved by the Director, the Chief of Staff, or their designee, if it is determined that it is not possible to handle the influx of patients with NWI's existing Practitioners. Any of the following will be accepted as credentials verification process for emergency volunteers to provide patient care in the facility:
    - i) Evidence of a current license (pocket card sufficient) to practice;
    - ii) And one of the following:
      - (1) A current medical facility photo ID card;
      - (2) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
      - (3) Identification that the individual has been granted authority to render patient care in emergency circumstances by a Federal, state, or municipal entity.
  - b. 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.
  - c. In circumstances where communication methods utilized to verify credentials fail or are unavailable beyond the ten (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 sixty (45) working days.
  - d. An assigned, appropriately credentialed and privileged physician oversees the professional practice of each volunteer, Licensed Independent Practitioner, Midlevel Practitioner, and Allied Health Practitioner.
  - e. the quality of the care and services 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 seven (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 1100.19.
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 credentials 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. 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 Credentials Committee for review and recommendation to the Executive Committee of the Medical Staff (XCOM) for action. The documents reviewed, the determination, and the rationale for the determination of the Executive Committee of the Medical Staff (XCOM) 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 where 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 45 calendar days, during which time the credentialing and privileging process must be completed. In order to qualify for this temporary appointment, when returning from active duty the following must be documented in VetPro:

- i) Verification that all licenses that were current at the time of deployment and/or activation are current and unrestricted with no previous or pending adverse actions on the Temporary Enrollment Screen;
- ii) Registration with the NPDB-HIPDB PDS with no match;
- iii) A response from the FSMB with no match;
- iv) Marking of the Temporary Enrollment Screen as reinstatement from Deployment and/or Activation; and
- iv) Documentation of the Temporary Appointment on the Appointment Screen not to exceed 45 calendar days.

#### 8.07 MEDICAL ASSESSMENT

A medical history and physical examination is completed within thirty (30) days before admission or registration. The practitioner must complete and document an updated examination of the patient within twenty-four (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.

## ARTICLE IX. INVESTIGATION AND ACTION

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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, Disruptive Behavior, 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 a committee named by the Chief of Staff, with responsibility for conducting review.
3. **Review by Investigating Committee:** The Investigating Committee given responsibility for conducting review shall investigate the charges and makes a report of its investigation to the Executive Committee of the Medical Staff within fourteen (14) days after the Investigating Committee 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 Investigating Committee 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 Investigating Committee 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 Executive Committee of the Medical Staff.
4. **Executive Committee of the Medical Staff Action:** Within fourteen (14) days after receipt of a report from the Investigating Committee, the Executive Committee of the Medical Staff acts upon the request. If the action being considered by the Executive Committee of the Medical Staff 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 Executive Committee of the Medical Staff 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 Executive Committee of the Medical Staff.

- a. The Executive Committee of the Medical Staff 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 Executive Committee of the Medical Staff 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<sup>1</sup>, 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.
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 Investigating Committee to investigate the matter, meet with the Practitioner if requested and make a report thereof to the Executive Committee of the Medical Staff 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.
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:
    - i) The Practitioner is being investigated, indicted or convicted of a misdemeanor or felony that could impact the quality and safety of patients.
    - ii) Failure on the part of any staff member to complete medical records in accordance with system policy may result in progressive disciplinary action to possible indefinite suspension.
    - iii) The Practitioner is being investigated for fraudulent use of the Government credit card.
    - iv) Failure to maintain the mandatory requirements for membership to the medical staff.
  - b. The Chief of Staff convenes the Investigating Committee to investigate the matter and make a report thereof to the Executive Committee of the Medical Staff 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.

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<sup>1</sup> See the definition of Proctoring for an explanation of the difference between proctoring and supervision.

7. Actions Not Constituting Corrective Action: The Investigating Committee 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.

## ARTICLE X. FAIR HEARING AND APPELLATE REVIEW

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### 1. Reduction of Privileges:

- Prior to any action or decision by the Director regarding reduction of privileges, the Practitioner will receive written notice of the proposed changes in privileges from the Chief of Staff. The notice will include:
  - i) A description of the reason(s) for the change.
  - ii) A statement of the Practitioner's right to be represented by counsel or a representative of the individual's choice, throughout the proceedings.
- 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 ten (10) 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 ten (10) additional workdays except in extraordinary circumstances.
- 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 five (5) workdays after receipt of the Practitioner's request for hearing. These three professionals will conduct a review and hearing. At least two (2) 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 twenty (20) workdays and not more than thirty (30) workdays from the date of notification letter.
  - b. During such hearing, the Practitioner has the right to:
    - i. Be present throughout the evidentiary proceedings.
    - ii. Be represented by an attorney or other representative of the Practitioner's choice. If the Practitioner is represented, this individual is allowed to act on behalf of the Practitioner including questioning and cross-examination of witnesses.
    - iii. Cross-examine witnesses.
  - c. 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 fifteen (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 ten (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 five (5) workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the Director's decision is overturned on appeal, the report to the NPDB must be withdrawn.

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

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

The hearing panel chair shall do the following:

- 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.
- 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 fifteen (15) hours.
- Maintain decorum throughout the hearing.
- Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence.
- 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.
- Conduct argument by counsel on procedural points and do so outside the presence of the hearing panel.
- Seek legal counsel when he or she feels it is appropriate. Regional Counsel to the facility should advise the panel chair.

Practitioner Rights:

- 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.
- The panel will complete its review and submit its report within fifteen (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.

- The Director will issue a written decision within ten (10) 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.
- The Practitioner may submit a written appeal to the VISN Director within five (5) workdays of receipt of the Director's decision.
- The VISN Director will provide a written decision based on the record within twenty (20) workdays after receipt of the Practitioner's appeal. The decision of the VISN Director is not subject to further appeal.
- 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 (5) workdays after receipt of the Director's decision.
- 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.
- 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:

- Proposed action taken to revoke a Practitioner's privileges will be made using VHA procedures.
  - i) 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.
  - ii) 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.
- 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. Any recommendation by the Executive Committee of the Medical Staff 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<sup>2</sup>:

- 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.

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<sup>2</sup> Reference VHA Handbook 1100.17.

- 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.
  - 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.
  - 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.
  - VA only reports adverse privileging actions that adversely affect the clinical privileges of Physician 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 thirty (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 thirty (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.

## ARTICLE XI. AMENDMENTS

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1. The Bylaws are reviewed at least every two (2) 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 the Executive Committee of the Medical Staff. 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 majority vote endorsement by the voting members of the active medical staff who are present at the time the proposal takes place.
2. The Executive Committee of the Medical Staff 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 comment on the provisional amendment. If there is no conflict, the adoption of the urgent amendment will stand approved. Should a conflict arise, the Conflict Management process noted in Article III, Section 3.04 should be followed.
3. Written text of proposed significant changes is to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and are notified of the date proposed changes are to be considered.
4. All changes to the Bylaws require action by both the Organized Medical Staff and Facility Director. Neither may unilaterally amend the Bylaws.
5. Changes are effective when approved by the Director.

## ARTICLE XII. ADOPTION

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

If the voting members of the Organized Medical Staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they must first communicate the proposal to the Executive Committee of the medical Staff. If the Executive Committee of the medical proposes to adopt a rule, regulation, or policy, or an amendment thereto, they must first communicate the proposal to the Organized Medical Staff.

### RECOMMENDED:

Grace L. Stringfellow, MD      8/25/14  
GRACE L. STRINGFELLOW, M.D.      Date  
Chief of Staff

### APPROVED:

Marci Mylan      8-25-14  
MARCI MYLAN, Ph.D.      Date  
Director