

September 30, 2013

The Honorable Carolyn Lerner

Special Counsel

U.S. Office of Special Counsel

1730 M. Street, NW, Suite 300

Washington, DC 20036-4505

Re: OSC File No. DI-13-2644

Dear Ms. Lerner:

Below are my comments on the U.S. Department of Veterans Affairs Office of the Medical Inspector Report of my whistleblower complaints about the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi.

The G.V. Sonny Montgomery VA Hospital (GVSMVAMC) in Jackson, MS has been the subject of much negative attention recently due to unethical administrative practices and disregard for health and safety. The VISN and hospital management failed to respond quickly to correct these wrongs and chose instead to issue a public relations denial, citing the administration's commitment to our veterans as the shield management raises to deflect attention from the real situation.

The GVSMVAMC was cited by the Office of Special Counsel (case DI -12-3816) for not following proper credentialing and privileging policies of licensed independent practitioners. In fact, at one point a motion in the CEB to return the credentialing and privileging process to that required by the medical staff bylaws and VAH Handbook 1100.19 policies was voted down by the clinical executive board committee. The vote in the CEB was divided along a line between service chiefs and elected members of the medical

staff. It is noteworthy that service chiefs continue to benefit enormously by avoiding the prescribed process. Doing so provides them the ability to hire faculty without any scrutiny from non-management members of the medical staff. Expeditious and efficient management of credentialing paper work has been the excuse provided by the hospital leadership for supporting and maintaining an unsafe process to approve and re-approve credentialing of clinical providers.

Gina Jackson, VA spokeswoman, was quoted recently in response to media attention to the September 9, 2013 field hearing of the House Committee on Veterans Affairs involving a multitude of VA facilities with gross mismanagement. She stated that "If employee misconduct or failure to meet performance standards is found to have been a factor, VA will take appropriate corrective action immediately." This VA's response has actually been quite the opposite. Instead of responding to the OMI's findings of failure to use the proper credentialing procedure, the administration of GVSMVAMC has practiced conscious disregard for the OMI's findings. The hospital administration congratulated itself by saying that according to the OMI's exit interview the process is right on track and an example to other VAs. This is a complete fabrication and a misrepresentation of the facts. This charade is ridiculous as evidenced by the OMI's findings.

Kathryn Enchelmayer's (Director, Credentialing and Privileging for the Veterans Health Administration) participation in this OMI was a total conflict of interest. Her name was repeatedly given as a reference by administration as the justification for their cover ups and failure to report negligent practitioners to national databases, failure to share information from peer reviews, external evaluations, and administrative boards of investigation, which according to regional counsel, are not "protected". However, Ms. Enchelmayer was defensive during the OMI investigation when confronted with this fact. It is not a coincidence that the Director of Credentialing and Privileging would find that there was no incorrect privileging of providers. Ms. Enchelmayer advised the administration on credentialing and privileging BEFORE the filing of my OSC complaint. She acted as an "enabler" of wrongdoing by the hospital management, by providing the cover of authority from VA Headquarters for the very processes she is now acting as chief investigator for the OMI review. Does the phrase "the fox guarding the hen house" ring any bells here?

After the OMI finding that the center did not and actually voted not to follow their own policy, how then can anyone say that no mistakes were made in this very flawed and nontransparent system? How can they fail to find that there was no intent to deceive? If providers have been credentialed by pushing them through a rigged committee process, how can this not constitute a substantial danger to public health and safety at the Medical Center?

The investigation concluded that PSB information was not provided completely or accurately to the CEB. Due to this lack of procedure, informed decisions could not be made regarding credentialing and privileging. The Director would sign off on PSB recommendations before the CEB had the chance to review the PSB minutes. Electronic poll voting is not even addressed in the medical staff bylaws, and voting results were completely fabricated. How could the OMI then conclude that none of this was done with intent to deceive? That is a completely ridiculous statement. The few PSB members that would meet to push through questionable providers were composed of individuals whose personal agendas represented a conflict of interest. In bypassing the CEB, the PSB definitely had the intent to deceive and then fabricated a poll vote in cover up.

I want to emphasize that a much larger issue is raised by the ophthalmologist's example which simply represents the most recent example of a deliberately subverted credentialing and privileging process. By submitting candidates for credentialing and recredentialing anonymously and in groups for computer poll votes, and falsifying practice information directly or by omission, the CEB was effectively bypassed. This is a patient safety issue, since the CEB is charged with the final vetting of individual practitioners who apply for medical staff membership. It bears repeating that the current broken process is a great boon for the hospital administrators, especially the service chiefs, who now have no check on the selection of staff providers for their services. This is the same situation that functioned in the credentialing of nurse practitioners who were not appropriately licensed or DEA certificated for the practice they engaged in. Hospital administrators have simply modified the process to suit themselves for their own goals and purposes without regard to the patient safety oriented prescribed process.

The improper reinstatement of privileges is another management technique used at our VA in order to abandon the prescribed VA required process when it interferes with a management goal. Patient care will continue to suffer as long as providers are credentialed and privileged improperly.

I will now provide further commentary on each of the committee's conclusions (pages 2-4).

1. The OMI substantiates that the Medical Center relied upon incorrect credentialing and privileging processes contrary to our bylaws. The PSB was a limited membership that was heavily weighted to service chiefs and thus innately presented a conflict of interest making it easy to guide the discussion and selectively present provider information. In conclusion one (page 2), the VA has used language to describe the PSB as made up of "executive members of the medical staff". This language implies that the PSB is somehow comprised of elite, special status members of the medical staff when in fact they are subordinate members of management. All their actions are subject to management approval. They all serve at the pleasure of the Governing Body of the hospital and their evaluations, compensation, and advancement are all dependent on pleasing the whims of the Governing Body members. This differentiates them from "elected" members of the CEB, who represent first and foremost the interests of the medical staff and their patients.
2. The VA excuses its deliberate violations of its own policies and guidelines by using the term "technically noncompliant" to describe the actions of the facility leaders (VISN officials, facility Governing Body, and the subordinate service chiefs". (page 3, paragraph #1, 4th line) This language is designed to excuse their actions by treating it as an innocent oversight or misunderstanding, when in fact, the decisions to pervert the credentialing and privileging process were made by design to circumvent the CEB. This language allows VACO to avoid any discipline of the facility leaders, and acts as a silent "blessing" of their actions. The VA has become a culture of reward for unethical and improper behavior by managers directly responsible for facility leadership, and by extension, directly responsible for the health, welfare, and safety of the patients.

3. The OMI's conclusion that it "found no evidence that there was intent to deceive by anyone by on the PSB" can only be described as preposterous! This conclusion flies in the face of the OMI's own finding of fact. This conclusion is an insult to the intelligence of anyone who reads it. The OMI's conclusion can only be understood within the context of the blatant conflict of interest Kathryn Enchelmayer has in this OSC complaint. She must protect herself from scrutiny of the advice given to and the decisions taken by the facility leadership that lead to this OSC complaint. Provider information did not fully include malpractice and disciplinary histories. Electronic poll voting process and results were fabricated. The CEB was not given complete PSB reviewed provider information in a timely fashion in which to make an informed decision. The Director signed off on PSB minutes prior to CEB meeting. The last line in statement 3 page 13 sums this up in stating that although there were **misstatements of facts**, OMI found no evidence that there was intent to deceive by anyone on the PSB. How are lies not an intent to deceive and how is this proven - by taking the PSB's word on this? The OMI's finding of "misstatements of facts" proves intent to deceive.

4. The conclusion of paragraph 4, page 3 of the VA response is Ms. Enchelmayer's, who chaired the OMI, way of diverting attention from her direct and repeated involvement in preventing the reporting of the involved providers to the NPDB and to the State Medical Licensure Board. Facility leaders have repeatedly stated in CEB meetings that they based their decisions on Ms. Enchelmayer's guidance. One recurring piece of advice that was cited to the CEB was that the local facility could "label" any action it took against a provider's privileges as "administrative" and the agency could avoid its ethical and legal obligation to report to the NPDB and to the state licensure board. This clearly violates the intent, requirements, and spirit of the rules and laws related to dealing with these outside agencies.

The OMI did not substantiate that improper credentialing and privileging practices may have resulted in incorrect privileging of providers. The conclusion section states there is overwhelming evidence that clinical leaders were intimately involved with those privileging actions and went to great lengths to evaluate and monitor the ophthalmologist within the PSB. That very conclusion is the issue. The clinical leaders involved were a select few on the PSB, not the CEB.

The aforementioned ophthalmologist has undergone a few suspensions, the most recent a ten month "summary suspension" after a sentinel event. During this latest suspension, the provider's privileges expired. The OMI did not find any evidence that this provider went through the CEB upon recredentialing/reprivileging only through PSBs and "special focus" PSBs. The CEB minutes reflect that two separate PSB meetings' minutes were "inadvertently not presented to the CEB meeting", but supposedly were given to the OMI after their site visit. Results from an outside peer review were not disclosed. The provider then underwent monitoring internally for 25 cataract surgical cases, which he failed to complete. His cataract surgical privileges were then removed "administratively". Ms. Enchelmayer was again asked for guidance as she had been consulted many times throughout this provider's history, and the decision was made that this removal of privileges was not reportable to the NPDB (National Practitioner's Data Bank). Her involvement represents a conflict of interest. What are actually DISCIPLINARY suspensions that policy requires be reported to the boards of medical licensure and NPDB are being labeled "administrative" to avoid the extra effort the local VA would have to exert, and more importantly, the personal embarrassment the local VA management and the VISN will be exposed to for their management decisions regarding their abandonment of VA credentialing policies.

According to the Medical Center Policies K-11P-60 and F-11P-34, this reduction of clinical privileges is reportable to the NPDB:

Attach Medical Staff Bylaws dated 9/28/12

Medical Center Policy Number: K-11P-60

December 31, 2012

Credentialing and Privileging of Independent Practitioners

E. Reduction and Revocation of Privileges:

1. Reduction of privileges may include, but not be limited to, restricting or prohibiting performance of specific procedures including 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. Revocation of privileges refers to the permanent loss of clinical privileges. If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures as outlined in Medical Staff Bylaws and VA regulations will be followed.

2. Any professional review action that adversely affects the clinical privileges of an independent practitioner for a period longer than 30 days; or any acceptance of the surrender of clinical privileges, or any restriction of such privileges by an independent practitioner either while the practitioner is under investigation by the medical center relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding; will be reported to the NPDB. Further information on the Reduction and Revocation of Privileges is found in medical Center Policy memorandum F-11P-34.

And according to VHA Handbook 1100.17 – National Practitioner Data Bank (NPDB) Reports:

3. SCOPE

VHA facilities must file a report with the NPDB in accordance with regulations in 45 CFR Part 60, Subpart B, as applicable, and 38 CFR Part 46 regarding:

a. Any payment for the benefit of a physician, dentist, or other licensed health care practitioner, which was made as the result of a settlement or judgment of a claim of medical malpractice, in accordance with the procedure outlined in 38 CFR Part 46.3(b), and

b. Adverse clinical privileges actions (e.g., restriction, suspension, revocation, etc.) taken against physicians and dentists that are final and affect privileges for more than 30 calendar days, as well as acceptance of the surrender of clinical privileges, or the restriction of clinical privileges of physicians and dentists, when the action is related to professional competence or professional conduct.

NOTE: *Malpractice payment reporting applies to all licensed health care professionals. Adverse action reporting applies only to physicians and dentists.*

To date, missing PSB minutes have not been disclosed and no written record of Ms. Enchelmayer's reasoning has been presented. CEB members have been asked individually to refrain from dissention during meetings in order to expedite meetings. Mandatory CEB training as required in VHA handbook 1100.19 has not been enforced. For a short time period, there was a return to the bylaws with combined PSB/CEB meetings in which CEB members were able to review provider charts and ask questions and request information from service chiefs. It was obvious that there were many glitches in the credentialing and privileging processes

which resulted in lengthy meetings. Often times providers privileges were held until the next meeting for clarification of missing information. This would lead to many "emergency" meetings in order for privileges not to expire. Service chiefs then complained of the length and number of meetings. Lately, there has been a shift backwards again to push all privileging and credentialing through the PSB with limited involvement of the CEB. There is still no clarification of what is protected from review even among internal committees such as quality assurance, credentialing and privileging, and regional counsel. Basically, policy verbiage is interpreted at the will of the administration, and if written policy is questioned they continue to hide behind verbal recommendations of regional counsel and Enchelmayer, and decline to provide written verification of such. This is an example of the conscious manipulation of the process to bypass the CEB's input to get problem providers credentialed and avoid the hospital's legal and ethical responsibility to report these providers to their state licensing boards so that those boards can make the independent decisions that they are charged with by law.

Those who ruffle the feathers of this administration are ostracized and admonished, and a substantial number of providers who had questionable paperwork and verification of training, and recommendations upon initial credentialing continue to resurface with clinical issues and concerns. Administration has made no real changes since this OMI inspection, only doing away with the guise of electronic poll voting which never existed in the first place. Meeting agendas are not consistently given in advance, discussion and access to provider files are still not allowed, and PSB minutes are incomplete and some remain missing. The administration denies receipt of a written formal report stating OMI's recommendations. Credentialing and privileging processes have not been revised to follow current VA policy, bylaws, nor local policy. Instead the bylaws have been rewritten by administration. These changes are being pushed through medical staff by stating that changes were recommended by a mock Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inspection, however JCAHO would have no interest in the PSB/CEB specifics and would not have issued these revisions.

In the Summary Statement of the VA's response (page 4) is the quintessential example of the moral decline of the culture of VA leadership.

The VA can find no abuse of authority. It can find no violation of regulations. It can find no specific danger to the public health and safety. It can find nothing wrong with its own actions, that it has self investigated with the chairwoman of the OMI having a total conflict of interest in the issues of my complaint. The VA can no longer claim to be worthy of the public trust, nor can it claim to be a fiduciary for the health and safety of the veteran beneficiaries.

Attachments:

VHA handbook 1100.17 and NPDB Reports

Medical Center Policies K-11P-60

VHA handbook 1100.19 Credentialing and Privileging

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b. Adverse clinical privileges actions (e.g., restriction, suspension, revocation, etc.) taken against physicians and dentists that are final and affect privileges for more than 30 calendar days, as well as acceptance of the surrender of clinical privileges, or the restriction of clinical privileges of physicians and dentists, when the action is related to professional competence or professional conduct.

NOTE: Malpractice payment reporting applies to all licensed health care professionals. Adverse action reporting applies only to physicians and dentists.

To date, missing PSB minutes have not been disclosed and no written record of Ms. Enchelmayer's reasoning has been presented. CEB members have been asked individually to refrain from dissention during meetings in order to expedite meetings. Mandatory CEB training as required in VHA handbook 1100.19 has not been enforced. For a short time period, there was a return to the bylaws with combined PSB/CEB meetings in which CEB members were able to review provider charts and ask questions and request information from service chiefs. It was obvious that there were many glitches in the credentialing and privileging processes which resulted in lengthy meetings. Often times providers privileges were held until the next meeting for clarification of missing information. This would lead to many "emergency" meetings in order for privileges not to expire. Service chiefs then complained of the length and number of meetings. Lately, there has been a shift again to push all privileging and credentialing through the PSB with limited involvement of the CEB. There is still no clarification of what is protected from review even among internal committees such as quality assurance, credentialing and privileging, and regional counsel. Basically, policy verbiage is interpreted at the will of the administration, and if written policy is questioned they continue to hide behind verbal recommendations of regional counsel and Enchelmayer, and decline to provide written verification of such. Those who ruffle the feathers of this administration are ostracized and admonished, and a substantial number of providers who had questionable paperwork and verification of training and recommendations upon initial credentialing continue to resurface with clinical issues and concerns.

This is an example of the conscious manipulation of the process to bypass the CEB's input to get problem providers credentialed and avoid the hospital's legal and ethical responsibility to report these providers to their state licensing boards so that those boards can make the independent decisions that they are charged with by law.

Attachments:

VHA handbook 1100.17 and NPDB Reports

Medical Center Policies K-11P-60

VHA handbook 1100.19 Credentialing and Privileging

NATIONAL PRACTITIONER DATA BANK (NPDB) REPORTS

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook contains requirements for health care facilities' participation in Department of Veterans Affairs (VA)-mandated paid malpractice claim review process and the process for reporting information to the National Practitioner Data Bank (NPDB) regarding physicians, dentists, and other licensed health care professionals.

2. SUMMARY OF CONTENTS/MAJOR CHANGES. This Handbook specifies:

a. The required procedure for notification of practitioners involved in the care that led to the claim through clarification of this process.

b. The specific procedures for assembly of information by facilities for submission to the Office of Medical-Legal Affairs (11ML).

c. The requirement for timely submission of information required for the paid malpractice claim review process.

d. The criteria and process for reconsideration of the determination made by the Review Panel.

3. RELATED DIRECTIVES. VHA Directive 1100 (to be published).

4. RESPONSIBLE OFFICE. Office of Quality and Performance (10Q), the Office of Patient Care Services (11), and the Office of Medical-Legal Affairs (11ML) are responsible for the contents of this Handbook. Questions may be addressed to 919-474-3905.

5. RESCISSEMENTS. VHA Handbook 1100.17, dated November 13, 2002, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of December 2014.

Gerald M. Cross, MD, FAAFP
Acting Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publication Distribution List 12/28/09

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NATIONAL PRACTITIONER DATA BANK (NPDB) REPORTS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook specifies the requirements for health care facilities' participation in Department of Veterans Affairs (VA)-mandated paid malpractice claim review process and the process for reporting information to the National Practitioner Data Bank (NPDB) regarding physicians, dentists, and other licensed health care professionals.

NOTE: This Handbook does not apply to individuals in training programs, other than licensed physician and dental residents (see subpars. 8b(2) and 8b(3)).

2. BACKGROUND

a. Under the provisions of the Health Care Quality Improvement Act of 1986 (Public Law (Pub. L.) 99-660), which established the NPDB, and a Memorandum of Understanding (MOU) between VA and the Department of Health and Human Services (HHS), reports of certain malpractice payments and certain clinical privileges actions must be submitted to the NPDB and appropriate state licensing boards for VA practitioners. Regulations in Title 38 Code of Federal Regulations (CFR) Part 46 published in the Federal Register on April 23, 2002, set forth VA policy regarding participation in NPDB reporting requirements. These reporting requirements apply to all VHA physicians, dentists, and other licensed health care practitioners involved in patient care who are employed, appointed, or contracted for, under job titles listed in the NPDB document entitled "Occupation/Field of Licensure Codes" on a full-time (FT), part-time (PT), intermittent, consultant, attending, without compensation (WOC), on-station fee-basis, on-station contract, on-station scarce medical specialty, mutual use, or sharing agreement basis. Since the NPDB is unable to ensure the identity of any individual in the absence of a license number, individuals who do not have a license will not be reported, except in special circumstances as outlined in subparagraph 8i(5).

b. For purposes of this Handbook, a malpractice payment is a payment, by way of settlement or judgment, by the United States on a claim of medical malpractice as defined in 38 CFR Section 46.1(b).

c. For purposes of this Handbook, adverse action is defined as reduction, suspension, denial (other than initial), nonrenewal, or revocation of privileges for a period exceeding 30 calendar days.

3. SCOPE

VHA facilities must file a report with the NPDB in accordance with regulations in 45 CFR Part 60, Subpart B, as applicable, and 38 CFR Part 46 regarding:

a. Any payment for the benefit of a physician, dentist, or other licensed health care practitioner, which was made as the result of a settlement or judgment of a claim of medical malpractice, in accordance with the procedure outlined in 38 CFR Part 46.3(b), and

b. Adverse clinical privileges actions (e.g., restriction, suspension, revocation, etc.) taken against physicians and dentists that are final and affect privileges for more than 30 calendar days, as well as acceptance of the surrender of clinical privileges, or the restriction of clinical privileges of physicians and dentists, when the action is related to professional competence or professional conduct.

***NOTE:** Malpractice payment reporting applies to all licensed health care professionals. Adverse action reporting applies only to physicians and dentists.*

4. RESPONSIBILITY OF THE REGIONAL COUNSEL

The Regional Counsel is responsible, by encrypted electronic mail, for:

a. Providing notification to the Directors of all involved medical centers, with copies to Chiefs of Staff and Quality Managers of all involved medical centers, the Veterans Integrated Service Network (VISN) Director, and VISN Chief Medical Officer that a medical malpractice claim has been filed under the Federal Tort Claims Act (FTCA). The notification to the Quality Managers of all involved medical centers needs to include a copy of Standard Form (SF) 95, Claim for Damage, Injury, or Death.

b. Providing notification to the Directors of all involved medical centers, with copies to Chiefs of Staff and Quality Managers of all involved medical centers, the VISN Director, and VISN Chief Medical Officer that a medical malpractice claim has been paid.

c. Providing, upon payment of a medical malpractice claim, pertinent documents including, but not limited to, the SF 95 and "VA Tort Claim Information System" printout to the Director, Office of Medical-Legal Affairs.

5. RESPONSIBILITY OF THE DIRECTOR, OFFICE OF MEDICAL-LEGAL AFFAIRS

The Director, Office of Medical-Legal Affairs, is responsible for coordinating the paid malpractice claim review process. In this context, the Director:

a. Receives the Regional Counsel's notification of malpractice payment.

b. Requests Medical Center Director(s) to provide, in accordance with subparagraph 8d, all documentation pertinent to the episode of care that led to the claim. A copy of this request is sent to the VISN Director, VISN Chief Medical Officer, and the VA medical center Chiefs of Staff, the Quality Managers, and the Risk Managers.

c. Selects and appoints the members of the paid malpractice claim Review Panel.

d. Moderates and serves as advisor to the Review Panel.

e. Summarizes the episode of care that led to the claim and the rationale for the Review Panel's determination regarding the standard of care rendered. Provides this information to the Director(s) of the involved medical center(s), with copies to the VISN Director, the VISN Chief Medical Officer, and the Chiefs of Staff, Quality Managers, and NPDB coordinators of the involved medical center(s), along with certification of the panel's conclusions signed by all panel members.

f. Receives from the Medical Center Director, a copy of submitted NPDB report(s).

6. RESPONSIBILITY OF THE MEDICAL CENTER DIRECTOR

Each Medical Center Director is responsible for:

a. Receiving Regional Counsel notification of malpractice payment.

b. Reporting and providing a copy of a paid claim to the Director, Office of Medical-Legal Affairs, for any payment made by VISN Directors and Medical Center Directors for monetary claims for \$2,500 or less filed under FTCA. *NOTE: Nothing in this Handbook relieves the facility Director of responsibility from any other VHA requirements for the review of Tort Claims.*

c. Providing written notification to all involved practitioners, within 30 calendar days of notification by Regional Counsel, that a claim has been filed.

d. Providing, upon notification by Regional Counsel, notification to all involved practitioners, in accordance with subparagraph 8c(2), that a claim has been paid.

e. Ensuring that all documents pertinent to the episode of care that led to the claim are provided to the Director, Office of Medical-Legal Affairs, in accordance with the requirements stated in subparagraph 8d.

f. Reviewing the conclusions of the paid malpractice claim Review Panel for further action.

g. Notifying the involved practitioner(s) of the Review Panel's conclusions.

h. Filing a report with NPDB and appropriate State Licensing Boards (SLBs) in accordance with requirements outlined in this Handbook (see subpar. 8i).

i. Acting as the authorized representative for all submissions to the NPDB. Any delegation of authority for submission of reports to other facility officials must be documented in writing to include date of delegation and circumstances governing delegation. The authorized representative for purposes of making reports must be limited to a formally-designated Acting Director. Copies of reports to the NPDB and related documentation must be filed in the reported individual's Credentialing and Privileging Folder.

NOTE: Paragraph 8 addresses the review process for, and NPDB reports related to, malpractice payments. Paragraph 9 addresses reports related to clinical privileges actions, and includes guidelines for formal review procedures to be followed prior to initiating such reports.

- j. Providing the Office of Medical-Legal Affairs, within 30 calendar days of notification, a copy of the submitted NPDB report.
- k. Ensuring that the requirements of this Handbook are incorporated into appropriate medical center publications.
- l. Ensuring that actions taken under these procedures are strictly followed and documented.

NOTE: VHA officials are expressly prohibited from entering into formal or implied agreements not to report an employee in return for a personnel action, such as in: resignation, retirement, accepting a reassignment, etc. VHA officials cannot enter into formal or implied agreements to restrict information that would otherwise be reported under the provisions of this Handbook.

7. RESPONSIBILITY OF THE CHIEF PATIENT CARE SERVICES OFFICER

The Chief Patient Care Services Officer is authorized to submit the report concerning a medical malpractice payment reviewed pursuant to paragraph 8i(6) to the NPDB and is responsible for providing copies to the Medical Center Director, the practitioner, and SLBs. This is done in cases where the Chief Patient Care Services Officer deems it appropriate to do so following the review panel's determination that a malpractice payment has been made for the benefit of a physician, dentist, or other licensed health care practitioner.

8. MALPRACTICE PAYMENTS

a. **Parameters for Reporting Licensed Practitioners.** All licensed health care practitioners must be reported according to the requirements of this Handbook.

b. **Parameters for Reporting Licensed Trainees.** All licensed health care trainees must be reported according to the requirements of this Handbook.

(1) Attending staff (including contract employees, such as scarce medical specialists) are responsible for actions of interns and residents assigned under their supervision.

(a) Where the actions of a licensed trainee warrant reporting (for substandard care, professional incompetence, or professional misconduct), but did not result from gross negligence or willful professional misconduct, the attending is to be reported without mention of an involved trainee, but with a notification that the attending is being reported in a supervisory capacity.

(b) In circumstances where the Review Panel concludes that the payment of a claim was related to substandard care, professional incompetence, or professional misconduct resulting from gross negligence or willful professional misconduct on the part of a licensed trainee in a training or residency program, the trainee must be reported to the NPDB. **NOTE:** *In this*

instance, the attending is not reported unless the Review Panel concludes there was substandard care, professional incompetence, or professional misconduct on the part of the attending in the supervisory role.

(2) Physician residents who function outside the scope of their training program, e.g., who are appointed as the Admitting Officer of the Day (AOD), are to be considered and reported, if appropriate, as attending physicians.

(3) Unlicensed trainees are not to be reported since the NPDB is unable to ensure the identity of any individual in the absence of a license number, except in special circumstances as outlined in subparagraph 8i(5).

c. Practitioner Notification

(1) Practitioner Notification Prior to Payment

(a) The Medical Center Director identifies all practitioners involved in the episode of care that led to the claim.

(b) The Medical Center Director provides written notification to all involved practitioners that a claim has been filed within 30 calendar days of notification by Regional Counsel.

(c) A practitioner may consult an attorney at the practitioner's own expense. Regional Counsel is not authorized to represent the practitioner in matters related to Data Bank reporting. **NOTE:** *It is VA policy that each Medical Center Director must provide written notification to all licensed practitioners, who were assigned to provide care to a patient, when such care results in a claim for medical malpractice, within 30 calendar days from the date that Regional Counsel notifies the Director that a claim for medical malpractice has been filed under FTCA.*

NOTE: *In the event of payment, the Medical Center Director must notify all involved practitioners of the opportunity to submit a written statement to the Review Panel. Therefore, it is recommended that the Medical Center Director maintain a current verified address for all practitioners involved in all filed claims. The Medical Center Director may wish to maintain contact with the Regional Counsel regarding the status of filed claims.*

(2) Practitioner Notification Post Payment

(a) The Medical Center Director is responsible for notifying all involved practitioners of the opportunity to provide a written statement concerning the care that led to the claim for consideration by the Review Panel.

(b) For each involved practitioner, the Medical Center Director's notification must be in writing and hand-delivered or sent to the practitioner's current verified business or home address. If the practitioner is deceased, this information must be forwarded to the Review Panel in place of a written statement.

(c) For each involved practitioner, the Medical Center Director's notification must state that VA is considering whether to report the practitioner to the NPDB because of a specified malpractice payment. Reporting to the NPDB is based on the finding by a Review Panel that there was substandard care, professional incompetence, or professional misconduct during an episode of care. Attending staff are responsible for actions of health professional trainees assigned to their supervision. When licensed residents in training are identified as providers of substandard care, professional incompetence, or professional misconduct, the attending physician may be reported in the supervisory capacity, without mention of the licensed trainee except where the trainee's care is described as gross negligence or willful professional misconduct. In this case, the licensed trainee is to be reported without mention of the attending.

(d) For each involved practitioner, the Medical Center Director's notification must state that the request for a statement does not imply blame or fault, but, rather, is the practitioner's opportunity to submit information for consideration by the Review Panel.

(e) For each involved practitioner, the Medical Center Director's notification must state that:

1. The practitioner has the opportunity to submit a written statement concerning the care that led to the claim.

2. The practitioner is allowed 60 calendar days from receipt of notification and access to the medical record to submit the statement to either the Medical Center Director or the Director, Office of Medical-Legal Affairs.

3. The written statement is the practitioner's only opportunity to submit information for consideration by the Review Panel.

(f) For each involved practitioner not submitting a statement, the Medical Center Director is responsible for documenting that the involved practitioner received notification of the opportunity to submit a written statement. Written acknowledgement of receipt from the practitioner must be obtained. A copy of the certified mail return receipt postcard signed by the practitioner is acceptable documentation of receipt as is a delivery service (e.g., FedEx, United Parcel Service (UPS)) tracking record signed by the practitioner. A copy of the letter of notification with the practitioner's dated signature verifying receipt is also acceptable documentation. If a receipt is not returned, is not signed, or is signed by someone other than the practitioner, follow-up with the practitioner is required to document that the practitioner, in fact, received the notification. Acceptable follow-up with the practitioner includes, but is not limited to, email, fax, and telephone with documentation of follow-up on VA Form 119, Report of Contact.

(g) If an involved practitioner cannot be located, the Medical Center Director must provide documentation of the comprehensive efforts made to locate and contact that practitioner. Information sources that may prove useful in locating a practitioner include, but are not limited to: Human Resources Departments, Credentialing Offices, SLBs, specialty certification boards, educational institutions attended by the practitioner, and Internet searches.

(h) The Medical Center Director is responsible for providing all involved practitioners access to substantially the same medical record as that submitted for panel review. **NOTE:** *The records provided for review may have personally identifying information redacted to comply with statutes governing release of health information.*

NOTE: *Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not supersede the prerogative of the involved practitioner to access the medical record in preparation of a statement.*

NOTE: *If the medical record is no longer at the facility where the care that led to the claim occurred, it must be obtained.*

NOTE: *Without a routine use or written authorization permitting disclosure of the personally-identifying information of a living patient, practitioners who are no longer employed by VA or their attorneys may not access the relevant portion of the medical record, unless the data is de-identified in accordance with VHA Handbook 1605.1.*

(i) On a rare occasion, the Review Panel may identify an additional practitioner involved in the care that led to the claim. In this instance, the Medical Center Director must be informed by the Director, Office of Medical-Legal Affairs, and is responsible for notifying that practitioner as in accordance with subparagraphs 8c(2)(a)-(h). Submission of this required information must be in accordance with subparagraph 8d.

d. **Information Submitted For Panel Review.** The Medical Center Director is responsible for sending to the Director, Office of Medical-Legal Affairs, all information necessary for the Review Panel including, but not limited to:

(1) Medical records limited to records pertinent to the episode of care that led to the claim.

(2) Reports of Administrative Investigation Board(s) appointed to investigate the episode of care.

NOTE: *Records that are confidential and privileged under the provisions of Title 38 United States Code (U.S.C.) 5705 cannot be submitted.*

(3) A list of all involved practitioners with status (Attending, Resident, Registered Nurse (RN), Nurse Practitioner (NP), etc.).

(4) A copy of the Medical Center Director's letter of notification to each practitioner.

(5) A written statement from each practitioner or documentation of fulfillment of the required procedure for practitioner notification, in accordance with subparagraph 8c(2), if the practitioner has not submitted a statement.

(6) All other information associated with the episode of care that led to the claim.

(7) Other information or documents requested by the Director, Office of Medical-Legal Affairs.

e. **Organization of Information Submitted For Panel Review.** All information is to be organized as follows and sent in one package to Director, Office of Medical-Legal Affairs.

(1) All material must be legible, sectioned using letter size tabbed indexes, labeled as detailed in subparagraph 8e(2), and in chronological order (earliest date first) within each section.

(2) Information is to include, in the following order:

(a) Tab labeled "Practitioners:"

1. List of licensed practitioners involved in the episode of care that led to the claim, including profession and specialty and/or subspecialty, and the status of each practitioner at the time of the episode (i.e., Resident or Fellow), if applicable.

2. A copy of the Medical Center Director's letter notifying each practitioner of the opportunity to submit a written statement.

3. A written statement from each practitioner.

4. For each practitioner not providing a statement, documentation of receipt of notification in accordance with subparagraph 8c(2).

(b) Tab labeled "Admissions," with tabs for each admission pertinent to the episode of care that led to the claim, in chronological order (earliest date first); the following information must be included in the appropriate section tabbed accordingly:

1. Tab labeled "Discharge Summary" with date of admission and date of discharge.

2. Tab labeled "Emergency Department." Include written information such as VA Form 10-10M, Medical Certificate, or other documents.

3. Tab labeled "Operative Reports." Include physician's dictated operative report, nurse intraoperative report, anesthesia intraoperative clinical report, and patient consent.

4. Tab labeled "Inpatient Progress Notes."

5. Tab labeled "Consultation Reports."

6. Tab labeled "Radiology Reports." Include films and images with submitted information when pertinent to the episode of care that led to the claim.

7. Tab labeled "Laboratory Reports."

8. Tab labeled "Pathology and Autopsy Reports."

9. Tab labeled "Other." Include information pertinent to the episode of care that led to the claim not included in any of the preceding subparagraphs.

NOTE: Repeat the preceding sequence for each admission pertinent to the episode of care that led to the claim.

(c) Tab labeled "Outpatient Information" includes all outpatient records pertinent to the episode of care that led to the claim, in chronological order (earliest date first). The following information must be included within the appropriate section demarcated by a tab:

1. Tab labeled "Outpatient Progress Notes." Include primary care, consultations, and allied health progress notes.

2. Tab labeled "Radiology Reports." Include films and images with submitted information when pertinent to the episode of care that led to the claim.

3. Tab labeled "Laboratory Reports."

4. Tab labeled "Pathology Reports."

5. Tab labeled "Other." Include outpatient information pertinent to the episode of care that led to the claim not included in any of the preceding sections.

(d) Tab labeled "Administrative Board of Investigation Report."

(e) Tab labeled "Office of Medical-Legal Affairs Checklist." The checklist must be signed and dated by medical center Chief of Staff and packet preparer (see App. C).

f. **Timeliness of Information For Panel Review**

(1) The Director, Office of Medical-Legal Affairs must send a request to the Medical Center Director for information for submission to the Review Panel using encrypted email or other secure method of transmission.

(2) All information submitted for panel review needs to be sent by delivery service (such as FedEx, UPS, or United States Postal Service) with tracking capability.

(3) Materials not meeting the quality requirements as in accordance with subparagraphs 8c, 8d, and 8e are not appropriate for submission to the Review Panel and the complete submission will be returned in total to the Medical Center Director for revision and resubmission.

(4) The Office of Medical-Legal Affairs must receive all required materials in accordance with this Handbook no later than 75 calendar days from the date of Director, Office of Medical-Legal Affairs' request for submission of these materials.

g. Panel Review Process

(1) Upon receipt of the material from the Medical Center Director, the Director, Office of Medical-Legal Affairs, must assign a minimum of three healthcare professionals to be panelists. All panels must include a member of the same profession and specialty, as appropriate, of the individual whose practice is being reviewed. Other professionals are to be appointed as necessary. If the review of the episode of care requires specialty-specific knowledge, the panel may request a consultation from an appropriate specialist.

(2) Each panelist is assigned cases and is responsible for reviewing all materials pertinent to the care that led to the claim. The reviewing panelist prepares a summary of the review and presents it to the panel for discussion. The panel decides, by majority vote, if care that led to the claim constituted substandard care, professional incompetence, or professional misconduct and determines if the substandard care, professional incompetence, or professional misconduct for which the payment was made is attributed to a licensed practitioner. For care rendered by trainees, the criteria for reporting a trainee are gross negligence or willful professional misconduct.

(3) The non-voting Director, Office of Medical-Legal Affairs, or designee, must participate in person with the Review Panel to familiarize the panel members with VA policy and regulation and to provide direction.

(4) A prospective panelist is required to exclude himself or herself from participation in case consideration if either a provider or the claimant is:

(a) The panelist's spouse, minor child, or any relative with whom the panelist has a close personal relationship;

(b) A member of the panelist's household;

(c) A person with whom the panelist has a close personal relationship;

(d) A person for whom the panelist serves as a general partner, officer, director, trustee or employee;

(e) A person for whom within the last year the panelist has served as an officer, director, trustee, general partner, agent, attorney, consultant, contractor, or employee;

(f) A person for whom, to the panelist's knowledge, the panelist's spouse, parent, or any relative with whom there is a close personal relationship serves as an officer, director, trustee, general partner, agent, attorney, consultant, contractor, or employee;

(g) A person with whom the panelist is seeking employment or with whom the panelist has an arrangement for future employment; or

(h) A person with whom the panelist has, or seeks, a contractual, business, or other financial relationship, other than an employment relationship described in the previous clause.

h. Panel Review Determination

(1) The Director, Office of Medical-Legal Affairs, prepares a memorandum that includes a narrative summary of the patient care and the rationale for the Review Panel's conclusion that is sent to the Directors of all involved medical centers, with copies to the VISN Director, the VISN Chief Medical Officer, and the Chiefs of Staff, Quality Managers, and NPDB Coordinators, identified by the medical center, of all involved medical centers, along with certification of the panel's conclusions signed by all panel members.

(2) At the discretion of the Director, Office of Medical-Legal Affairs, the Review Panel may be asked to reconsider its determination based on submission of substantive new or additional information not previously available. The reconsideration process does not obviate the requirement for the Medical Center Director to submit the report to the NPDB within 30 calendar days of notification in accordance with subparagraph 8i. If reconsideration determines that the original report to the NPDB is to be voided, the Director, Office of Medical-Legal Affairs, must notify the Medical Center Director and copy those who were notified of the original determination. The Medical Center Director must notify the appropriate entities in accordance with subparagraph 8i(7).

(3) Upon case completion, the Office of Medical-Legal Affairs must contact the medical center Risk Manager to determine disposition of records and carry out the medical center Risk Manager's recommendation for disposition of the record.

(4) The records provided for review may have personally identifying information redacted to comply with statutes governing release of health information.

i. Submission of NPDB Reports

(1) Payment will be considered to have been made for the benefit of a physician, dentist, or other licensed health care practitioner when the Director, Office of Medical-Legal Affairs, notifies, per subparagraph 8h(1), the Medical Center Director that the conclusion (of at least a majority) of the Review Panel is that payment was related to substandard care, professional incompetence, or professional misconduct on the part of the physician, dentist, or other licensed health care practitioner. In any case where professional incompetence or professional misconduct is involved, coordination with other relevant processes should occur (e.g., Professional Standards Board, Disciplinary Appeals Board, or administrative investigations). Any coordination is not intended to delay processes outlined in this Handbook. Prior to submitting the report to the NPDB, the Medical Center Director may notify the practitioner to be reported in order to provide an opportunity for discussion with appropriate facility officials, including the Director, before the report is submitted. This discussion may only encompass issues surrounding the accuracy of the report and is not to be considered as an appeal of the merits of the determination that lead to the report. **NOTE:** *Review of content prior to submission could reduce later misunderstanding. The NPDB must send a copy of the*

computerized report to the facility and the practitioner with a limited comment period in which to make any changes in the facts of the report.

(2) The Medical Center Director must file a report with the NPDB, on behalf of the VA medical facility, or any remote clinics operated by VA, regarding any medical malpractice payment that the review procedures established was related to substandard care, professional incompetence, or professional misconduct on the part of a physician, dentist, or other licensed health care professional.

(3) Malpractice payments made as the result of a settlement, or judgment, of a claim of medical malpractice and subsequent to the formal review process, outlined in the preceding are to be reported to the NPDB, as well as a copy of the report to the SLB(s) in all state(s) where practitioners hold licenses, and in the state where a reportable episode of care occurred.

(4) A copy of the NPDB report must also be sent by the Medical Center Director to the Director, Office of Medical-Legal Affairs, within 30 calendar days of receipt of notification that the NPDB report is to be filed.

(5) If it is determined that a practitioner or trainee, past or present, claims or claimed a license that was not held, but would be reportable under provisions of this policy if a license was held, the practitioner must be reported to NPDB. **NOTE:** *In these cases, the Medical Malpractice Payment Report for NPDB report would be completed by inserting the words "No License," and attaching a statement signed by the facility's authorized representative explaining why the report is being filed without a license number.*

(6) Medical Center Directors are responsible for filing the report to NPDB within 30 calendar days of receipt of notice from the Director, Office of Medical-Legal Affairs, of the determination by the Review Panel that report(s) is to be made due to a finding of substandard care, professional incompetence, or professional misconduct on the part of the practitioner. Reconsideration of the panel's determination, in accordance with subparagraph 8h(2), does not obviate the requirement to file the report with the NPDB within the required 30 calendar days. Reports not made within this period are subject to reporting by the Chief Patient Care Services Officer.

(7) Any corrections, revisions, additions, or voiding of previously submitted reports are to be submitted to the NPDB, all SLB(s) previously notified, and any VA offices which received copies of the initial report. Canceled or voided reports must be removed from the practitioner's credentialing and privileging file and filed elsewhere with voided reports. In accordance with the NPDB, once the NPDB report has been voided and the notice of the void distributed to the practitioner, the reporting entity, and those who queried the NPDB and received the now-voided report within the last 3 years, the NPDB must never again disclose the existence of the now-voided report or the filing of the report to anyone. **NOTE:** *The Medical Center Director is responsible for advising previous recipients of this information that the report to NPDB has been voided.*

(8) Payments made for claims of malpractice in which the review panel determines that the standard of care was met and there was no professional incompetence or professional misconduct, or which the panel determines are due solely to circumstances beyond the control of the practitioner (including, but not limited to: power failure, accidents unrelated to patient care, drugs mislabeled by the supplier, equipment malfunction, etc.) are not to be reported.

(9) Claims that are closed without payment and compensation payments due to an award under the provisions of 38 U.S.C. 1151 are not reportable and are not to be referred to review panels.

j. **Exceptions to NPDB Reporting.** Examples of exceptions to NPDB reporting are:

(1) The practitioner, determined by the panel to be reportable, is a contractor or an employee of a contractor (or subcontractor or employee of a subcontractor) on behalf of whom a payment has been made in the case and who has been reported to the NPDB by a different entity.

(2) The practitioner, determined by the panel to be reportable, is an employee of another Federal agency. *NOTE: The Director, Office of Medical-Legal Affairs, informs the appropriate Federal agency.*

(3) The case arises from a Patient Alert based upon product recalls or similar institutional corrections not implicating an individual practitioner, at the discretion of the Director, Office of Medical-Legal Affairs, in consultation with the Assistant General Counsel (021).

k. **NPDB Report Forms.** Reports to the NPDB are to be submitted electronically using software provided by the NPDB. These include:

(1) **The Medical Malpractice Payment Report.** Submission of an initial report or correction, revision, addition, or voiding of a previously submitted report must be in accordance with instructions on the NPDB website at: www.npdb-hipdb.hrsa.gov.

(2) **Any Additional Information.** Completion of information regarding any medical malpractice payment report for which the initial reporting form does not allow adequate space to provide all relevant information must be in accordance with instructions on the NPDB website at: www.npdb-hipdb.hrsa.gov.

9. ADVERSE ACTIONS

a. **Parameters for Reporting Adverse Actions**

(1) When the Medical Center Director renders a final determination based on a clinical professional review, relating to possible incompetence or improper professional conduct, that adversely affects the clinical privileges of a physician or dentist by reducing, restricting, suspending, revoking, or failing to renew such privileges for a period longer than 30 days, such action must be reported.

(2) The acceptance of the surrender of clinical privileges, or any restriction of such privileges, by a physician or dentist while such physician or dentist is under investigation by the health care entity for possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding, whether or not the individual remains in VA service, is reported in accordance with NPDB policy. At the time a physician or dentist surrenders, or voluntarily accepts restriction of clinical privileges, resigns, or retires from the medical position in VA while under investigation for possible professional incompetence or improper professional conduct, the physician must be formally notified that reporting to the NPDB is required. The physician must be offered due process (as outlined in VHA Handbook 1100.19) regarding reduction and revocation of privileges. Individuals who choose not to avail themselves of the due process procedures waive their right to due process and must be reported.

NOTE: *It is intended that the report be filed within 15 calendar days of the date the action is made final by signature of the VA Medical Center Director.*

b. Provisions for Reporting Adverse Actions

(1) Final Actions related to professional competence or conduct that adversely affect clinical privileges of a physician or dentist for a period longer than 30 calendar days must be reported to the NPDB and a copy of this report must be sent to the SLB in the state in which the facility is located and the SLB in all states where the practitioner holds licenses. This report is called an "Adverse Action Report" by the NPDB. **NOTE:** *For purposes of this Handbook, adverse action is defined as reduction, suspension, denial (other than initial), nonrenewal, or revocation of privileges for a period exceeding 30 calendar days.*

(a) Prior to reporting to any SLB or NPDB, appropriate internal VA medical center due process procedures, pursuant to the provisions of VHA Handbook 1100.19 regarding reduction and revocation of privileges, must be completed.

(b) Action taken to restore clinical privileges of physicians or dentists previously reported as restricted is to be reported in the same manner as the original report with copies to all recipients of the original report.

(c) Any corrections, revisions, additions, or voiding of previously submitted reports are to be submitted to the NPDB and SLB(s) in the same manner as the original report with copies to all recipients of the initial report.

NOTE: *Actions to restore privileges previously reduced, suspended, or revoked are not considered a void. Voided reports must be removed from the practitioner's credentialing and privileging file and filed elsewhere with voided reports. The Medical Center Director is responsible for advising previous recipients of this information, that the report to the NPDB has been voided.*

(2) Summary suspension of clinical privileges pending review by the executive committee of the medical staff or other review panel is not reportable. If final action related to professional competence or conduct is taken by the Medical Center Director following the review, both the

summary suspension and final action that adversely affect privileges for a period longer than 30 calendar days are reportable. *NOTE: For information on Summary Suspension of clinical privileges see VHA Handbook 1100.19.*

(3) The acceptance of the surrender of clinical privileges, including the surrender of clinical privileges inherent in resignation or retirement, or any restriction of clinical privileges by a physician or dentist either while under investigation by the facility for possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding whether or not the individual remains in VA service, must be reported to the NPDB. A copy of this report must be sent to the SLB in the state in which the facility is located and to the SLB in all states where the practitioner holds licenses.

(4) Independent contractors and/or subcontractors acting on behalf of VA are subject to the VA policies on credentialing and privileging and NPDB reporting. In the following circumstances, VA must provide the contractor and/or subcontractor with appropriate internal VA medical center due process, pursuant to the provisions of VHA Credentialing and Privileging policy regarding reduction and revocation of privileges, prior to reporting the contractor and/or subcontractor to the NPDB and filing a copy of the report with the SLB(s) in the state(s) in which the contractor and/or subcontractor is licensed and in which the facility is located:

(a) When VA terminates a contract and/or subcontract for possible incompetence or improper professional conduct, thereby automatically revoking the medical staff appointment and clinical privileges of the contractor and/or subcontractor.

(b) When the contractor and/or subcontractor terminates the contract and/or subcontract, thereby surrendering clinical privileges, either while under investigation relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding following appropriate due process procedures.

(c) When VA terminates the services (and associated medical staff appointment and clinical privileges) of a contractor employee or subcontractor employee under a continuing contract for possible incompetence or improper professional conduct.

c. Responsibility For Reporting Adverse Actions

(1) The Director of the VA medical center must file an adverse action report, on behalf of the VA medical facility and on behalf of any satellite clinics operated by them, within 15 calendar days of the date the action is made final by signature of the Medical Center Director, with the:

(a) NPDB,

(b) SLB in the state in which the facility is located (copy), and

(c) SLBs in all states in which the practitioner is licensed (copy).

(2) Prior to approving the report, the Medical Center Director must notify the practitioner to be reported and provide the practitioner an opportunity for discussion with appropriate facility officials, including the Medical Center Director, before the report is submitted. **NOTE:** *Review of content prior to submission reduces later misunderstanding. The NPDB must send a copy of NPDB's computerized report to the facility and the practitioner with a limited comment period in which to make any changes in the facts of the report.*

d. **Forms.** Reports to the NPDB must be submitted electronically using software provided by NPDB or on the appropriate form(s) provided by the NPDB. These include:

(1) **The Adverse Action Report.** The Adverse Action Report is used for submission of the initial report, correction, revision, addition, or voiding of a previously submitted report in accordance with instructions on the NPDB website at: www.npdb-hipdb.com .

(2) **Additional Information.** This is used for completing information regarding any Adverse Action Report for which the initial format does not allow adequate space to provide all relevant information in accordance with instructions on the NPDB website at: www.npdb-hipdb.com .

10. POST-NPDB REPORTING AND THE HHS DISPUTE PROCESS

a. Following the reporting by the facility to the NPDB, the NPDB must send a copy of the computerized report to the facility and to the practitioner (the Notification of a Report in the Data Bank(s)) with a limited comment period.

b. The practitioner can not submit changes to the report. If the practitioner believes the report contains factual inaccuracies, the practitioner must contact the reporting facility to request that it file a correction to the report in accordance with the NPDB's requirements. If the reporting facility declines to change the report, the provider may add a statement, initiate a dispute of the report in accordance with and through the NPDB dispute process, or both. **NOTE:** *HHS does have a dispute process for reports made to the NPDB. This process is external to VA and is initiated by the practitioner.*

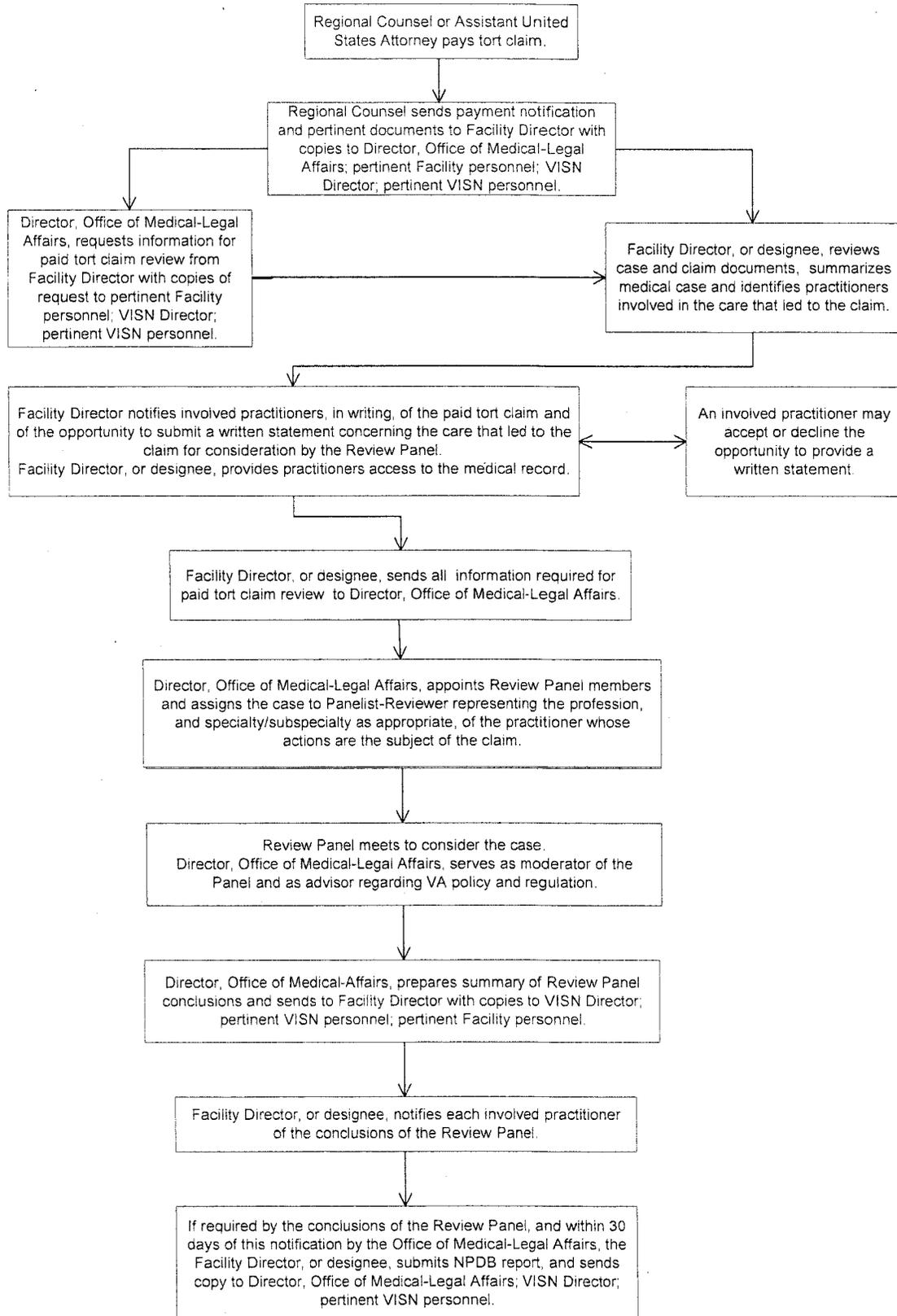
c. Practitioners who wish to add a statement to or dispute the factual accuracy of a report need to follow the instructions provided by the NPDB on the Notification of a Report in the Data Bank(s). The NPDB dispute process is not an avenue to protest a payment or to appeal the underlying reasons for reporting. Practitioners who wish to dispute the factual accuracy of the report or that the report was not submitted in accordance with NPDB reporting requirements may do so. Information on this process can be obtained from HHS through the NPDB.

11. REFERENCES

- a. Pub. L. 99-660 and its revisions (Pub. L. 100-177).
- b. Title 45 CFR Part 60.
- c. Title 38 CFR Part 46.

- d. Title 38 U.S.C. 7401 and 7405.
- e. MOU between HHS and VA, effective October 1, 1990.
- f. VA Handbook 5005.
- g. VA Handbook 5021, Part VI.
- h. Privacy Act System of Records Notice, 77VA10Q, Health Care Provider Credentialing and Privileging Records - VA.
- i. National Practitioner Data Bank Guidebook.
- j. VHA Handbook 1605.1

VHA PAID TORT CLAIM REVIEW PROCESS



SAMPLE FACILITY NOTIFICATION LETTER

Date: Month/Day/Year

From: Director, Office of Medical-Legal Affairs (11ML)

Subj: National Practitioner Data Bank Review Process

To: (Facility Director Name)
(Facility)

1. A payment has been made on a claim against the United States arising out of medical care provided at your facility in the case of:

Patient's Name:

Social Security Number (SSN):

2. The Office of Medical-Legal Affairs (OMLA) is required by Veterans Health Administration (VHA) regulation to conduct the Review Panel for this paid malpractice claim in accordance with the National Practitioner Data Bank (NPDB) reporting program. Your assistance in facilitating this review is required (Title 38 Code of Federal Regulations (CFR) Part 46 and VHA Handbook 1100.17). OMLA is to receive all required information for paid tort claim review no later than 75 calendar days from the date of this memorandum.

3. Practitioner Identification

a. Identify each practitioner involved in the episode of care which led to the claim and for which payment was made. *NOTE: If a resident is identified, the attending physician is also an involved practitioner.*

b. Inform each practitioner that the practitioner may be reported to the NPDB based on the conclusion of a Review Panel regarding the standard of care rendered.

4. Practitioner Statement

a. Offer each practitioner the opportunity to submit a written statement concerning the care that led to the claim. A request for a statement does not imply blame or fault. In accordance with VHA regulation, a practitioner is allowed 60 calendar days from receipt of notification and access to the medical record to submit a statement.

b. Notification of the opportunity to submit a statement is mandatory. The practitioner may accept or decline.

c. The practitioner must be provided access to substantially the same medical record as that submitted for panel review.

d. The written statement is the only opportunity in the review process for a practitioner to submit information for consideration by the Review Panel.

5. Practitioner Notification

a. For each involved practitioner, the Medical Center Director's notification must be in writing and hand-delivered or sent to the practitioner's current verified business or home address. If the practitioner is deceased, this information must be forwarded to the Review Panel in place of a written statement.

b. For each involved practitioner not submitting a statement, the Medical Center Director is responsible for documenting that the involved practitioner received notification of the opportunity to submit a written statement. Written acknowledgement of receipt from the practitioner must be obtained. A copy of the certified mail return receipt postcard signed by the practitioner is acceptable documentation of receipt as is a delivery service (e.g., FedEx, United Parcel Service (UPS)) tracking record signed by the practitioner. A copy of the letter of notification with the practitioner's dated signature verifying receipt is also acceptable documentation.

c. If the receipt is not returned, is not signed, or is signed by someone other than the practitioner, follow-up with the practitioner is required to document that the practitioner, in fact, received the notification. Acceptable follow-up with the practitioner includes, but is not limited to, email, fax, and telephone with documentation of follow-up on VA Form 119, Report of Contact. If an involved practitioner cannot be located, the Medical Center Director must provide documentation of the comprehensive efforts (e.g., query of relevant State Licensing Boards, internet search, query with medical center affiliates, liaison with credentialing office) made to locate and contact that practitioner.

d. The Medical Center Director is responsible for providing all involved practitioners access to the same medical record as that which was submitted for panel review.

6. Medical Chart Information

a. Provide organized legible copies of medical records pertinent to the care that led to the claim. **NOTE:** Follow VHA Handbook 1100.17 subparagraphs 8d and 8e to assemble the required information.

b. Information not meeting the requirements in VHA Handbook 1100.17 is not suitable for submission to the Review Panel and will be returned in total for revision and resubmission.

December 28, 2009

VHA HANDBOOK 1100.17
APPENDIX B

7. Send all information in one package to:

Director, Office of Medical-Legal Affairs (11ML)
VA WNY Healthcare System
3495 Bailey Avenue
Buffalo, NY 14215

8. Call (716) 862- 8521 with any questions.

cc: VISN Director
VISN Chief Medical Officer
VA Medical Center Chief of Staff
VA Medical Center Quality Manager
Risk Manager

OFFICE OF MEDICAL-LEGAL AFFAIRS CHECKLIST
COMPLETE, SIGN AND DATE, AND RETURN WITH YOUR PACKAGE

Patient Name _____ SS# _____

VISN _____ Medical Center _____

Preparer (PRINT) _____

Preparer (SIGN) _____ Date _____

Medical Center Chief of Staff (PRINT) _____

Medical Center Chief of Staff (SIGN) _____ Date _____

MEDICAL RECORDS Pertinent to the care that led to the claim: All materials must be legible, sectioned using letter size index tabs per below, and in chronological order (earliest date first) within each section.

	Enclosed	
	<input checked="" type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Tab "Admissions" Provide separated dated tabs for each admission.	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Discharge Summary:" Discharge summary	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Emergency Department:" Emergency department notes including 10-10M form and other handwritten information	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Operative Reports:" Dictated operative report, nursing intraoperative report, anesthesia intraoperative clinical report and patient consent	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Inpatient Progress Notes:" Inpatient admission and progress notes	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Consultation Reports:" Consultation reports	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Radiology Reports:" Radiology reports (send films and/or electronic images if relevant)	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Laboratory Reports:" Laboratory reports	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Pathology and Autopsy Reports:" Pathology and autopsy reports	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Other:" Specify	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Outpatient"	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Outpatient Progress Notes:" Outpatient evaluation and progress notes including primary care, consultations, and allied health notes	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Radiology Reports:" Radiology reports (send films and/or electronic images if relevant)	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Laboratory Reports:" Laboratory reports	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Pathology Reports:" Pathology reports	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Other:" Specify	<input type="checkbox"/>	<input type="checkbox"/>
Tab "Administrative Board of Investigation Report"	<input type="checkbox"/>	<input type="checkbox"/>
Administrative Board of Investigation (ABI) Report		
Date ABI Convened (if ABI not convened, so document)		
Tab "Office of Medical-Legal Affairs Checklist"	Required	
Office of Medical-Legal Affairs checklist signed and dated by preparer and medical center Chief of Staff		

INVOLVED PRACTITIONER INFORMATION (use additional lines if needed):

a. For each practitioner, provide a copy of the practitioner notification letter in compliance with VHA Handbook 1100.17. For each practitioner not providing a statement, submit documentation of practitioner's receipt of notification in compliance with VHA Handbook 1100.17.

PRACTITIONER NAME (TYPE OR PRINT)	Specialty or Subspecialty	Resident or Fellow		Practitioner statement enclosed		Practitioner receipt of notification enclosed	
		<input checked="" type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	<input checked="" type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	<input checked="" type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b. Submit this information for panel review by delivery service (such as FedEx, UPS, or USPS) with tracking.

c. Materials not meeting the quality requirements per VHA Handbook 1100.17 are not appropriate for submission to the Review Panel and the complete submission will be returned in total to the Medical Center Director for revision and resubmission.

d. The Office of Medical-Legal Affairs must receive all required materials in accordance with VHA Handbook 1100.17 no later than 75 calendar days from the date of the Office of Medical-Legal Affairs' request for submission of these materials.

SAMPLE PROVIDER NOTICE LETTER

Date:

From: Medical Center Director (00)

Subj: National Practitioner Data Bank Review Panel

To: (Insert Practitioner Name)

1. You have been identified as a participant in the episode of care of a patient treated at this facility that led to a tort claim. Since there was a paid settlement or judgment in favor of the claimant in the tort claim, you may be reported to the National Practitioner Data Bank (NPDB) according to Title 38 Code of Federal Regulations 46.
2. Reporting to the NPDB is based on the conclusions of a Review Panel that there was substandard care, professional incompetence, or professional misconduct. Attending staff are responsible for actions of interns and residents assigned under their supervision. When a licensed resident in training is identified as a provider of substandard care, professional incompetence, or professional misconduct, the attending physician may be reported in the supervisory capacity without mention of the licensed trainee, except when the resident's care is described as gross negligence or willful professional misconduct. In this case, the resident will be reported without mention of the attending.
3. Practitioners are provided an opportunity to submit a written statement concerning the care that led to the claim. The statement must be submitted to the Medical Center Director, or to the Director, Office of Medical-Legal Affairs, within 60 calendar days of your receipt of this memorandum. This is your only opportunity to provide information for consideration by the Review Panel. The request for a statement does not imply blame or fault, but, rather, is your opportunity to submit information for consideration by the Review Panel.
4. Payments made for claims of malpractice in which the Review Panel determines that the standard of care was met and there was no professional incompetence or misconduct, or which are due solely to circumstances beyond the control of the practitioner shall not be reported.
5. You may contact an attorney at your own expense. Regional Counsel is not authorized to represent you in matters related to Data Bank reporting.
6. Contact _____ (Name of appropriate individual) _____ at _____ (Telephone number) _____ at the time you receive this memorandum to answer questions and to arrange access to the medical record.

s//Medical Center Director

SAMPLE PANEL EXCLUSION LETTER

Date:

From:

Subj: Panelist's Guidelines

To: Director, Medical-Legal Affairs (11ML)

CASE IDENTIFIER: _____ «Last Name», «First Name» _____

Social Security Number (SSN): Last 4 numbers

1. I have reviewed the following restrictions for prospective Veterans Health Administration (VHA) National Practitioner Data Bank (NPDB) panelists. I have circled those that apply and hereby exclude myself from participating in panel review of the above referenced case.

- a. My spouse, minor child or any relative with whom I have a close personal relationship with is the claimant or practitioner;
- b. The claimant or practitioner is a member of my household;
- c. The claimant or practitioner is a person with whom I have a close personal relationship;
- d. The claimant or practitioner is a person for whom I serve as a general partner, officer, director, trustee or employee;
- e. The claimant or practitioner is a person for whom, within the last year, I have served as an officer, director, trustee, general partner, agent, attorney, consultant, contractor or employee;
- f. The claimant or practitioner is a person for whom, to my knowledge, my spouse, parent, or any relative with whom I have a close personal relationship serves as an officer, director, trustee, general partner, agent, attorney, consultant, contractor or employee;
- g. The claimant or practitioner is a person with whom I am seeking employment or with whom I have an arrangement for future employment; or
- h. The claimant or practitioner is a person with whom I have, or seek, a contractual, business, or other financial relationship, other than an employment relationship described in the previous clause.

2. None of the preceding apply to me, and I am able to serve on the panel.

(Signature) (Date)

SAMPLE REPORT OF REVIEW PANEL

Date:

From: Director, Medical-Legal Affairs (11ML)

Subj: Conclusions of Review Panel

To: Director (00)
VA Medical Center

CASE IDENTIFIER: _____ «Last Name», «First Name» _____
Social Security Number (SSN): Last 4 numbers

A three-member panel was convened on _____ (Insert Date) _____ to review the tort claim of _____ (Name of Referenced Patient) _____. The conclusions require reporting of the following provider(s) to the National Practitioner Data Bank (NPDB):

PROVIDER(S): Provider Name and Title

1. The act or omission for which payment was made according to the Regional Counsel:
2. Case Summary:
3. Panel Conclusion and Rationale:
4. A copy of the Panel's conclusions is to be made available to the involved practitioner(s).
5. The required report is to be submitted to the NPDB, and a copy forwarded to this office, within 30 calendar days of receipt of this memorandum. The NPDB sends a copy of the submitted report to the practitioner(s) with a limited comment period in which to make changes or append comments.
6. Copies of this report are to be sent to:

cc: VISN Director (10N__)
VISN Chief Medical Officer
VA Medical Center Chief of Staff
VA Medical Center Quality Manager
VA Medical Center NPDB Coordinator

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
G.V. (SONNY) MONTGOMERY VA MEDICAL CENTER

Medical Center Policy Number: K-11P-60

December 31, 2012

Credentialing and Privileging of Independent Practitioners

I. **PURPOSE:** To prescribe policies and procedures for credentialing and privileging of independent practitioners.

II. **POLICY:** All VHA health care professionals who are permitted by law and the facility to provide patient care services independently must be credentialed and privileged. The policies contained herein are applicable to all full-time, part-time, intermittent, consultant, attending, without compensation (WOC), on-station fee-basis, on-station contract, off-station contract, or on-station sharing agreement basis medical staff (independent practitioners) engaged or proposed to be engaged in clinical practice including supervision of resident physicians at this medical center. Independent practitioners assigned to Research or Administration not involved in patient care must be credentialed and placed on a scope of practice. This policy does not apply to residents, except those who function outside the scope of their training program; i.e., as Admitting Officer of the Day. Credentialing and Privileging must be completed prior to initial appointment or reappointment to the medical staff and before transfer from another medical facility.

A. General:

1. All medical staff members shall be fully credentialed and privileged prior to initial appointment or reappointment, except as identified in subparagraphs. All applicants applying for clinical privileges must be provided a copy of the Medical Staff Bylaws, Rules, and Regulations and must agree in writing to accept the professional obligations reflected therein.

2. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of 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 questions concerning these qualifications. Failure to provide necessary information, in a reasonable time frame, may serve as a basis for denial of medical staff appointment and/or privileges.

3. There is a mechanism established to assure that all individuals with clinical privileges provide services within the scope of individual privileges granted. Each service chief will ensure that persons with a "need-to-know" are provided access to the contents of privileges. For example, the operating room supervisor has a "need-to-know" who is privileged to perform surgery in the operating room. Therefore, he/she must have access to surgeon's privileges. Employees performing procedures outside the scope of their privileges may be subject to disciplinary or administrative action.

4. Medical staff appointments and privileges will not be granted for a period longer than the formal relationship with the facility. For example, if a contract has a finite end date, privileges may not be granted past the end date of the contract regardless of intent to renew. If a contract is terminated prior to expiration of the contract, privileges must be terminated since there is no legal agreement for the practitioner to provide care. Where the contract is terminated early based on substandard care, professional incompetence, or professional misconduct, privileges need to be revoked and a report made to the National Practitioner Data Bank, following appropriate due process procedures. Where substandard care, professional incompetence, or professional misconduct is not involved in the early termination of the contract, privileges must be terminated without regard to the due process requirements for privileging actions. This termination is not reportable to the NPDB.

5. Physician residents who function outside the scope of their training program; i.e., who are appointed Admitting Officer of the Day, must meet the C & P requirements of this policy.

6. A C & P folder will be established and maintained for each independent practitioner requiring privileges, according to the requirements of VA standardized folder identified in Appendix A. The Chief of Staff (COS) will be responsible for maintaining C & P folders.

B. Credentialing: The credentialing process includes verification, through appropriate primary sources, of the individual's professional education, training, licensure(s), and certification(s). It also includes review of health status, previous work experience, including any gaps in training and employment, clinical privileges, professional references, malpractice history, and adverse actions; or criminal violations, as appropriate. Employment commitments shall not be made until the credentialing process is completed and applicants have been properly screened through the appropriate state licensing boards, the Office of Inspector General (OIG) exclusion sanction list, the Federation of State Medical Boards (FSMB) for physicians, and submitting query to the National Practitioner Data Bank (NPDB). On a quarterly basis, all current medical staff will be screened through the OIG sanction list. Individuals reappointed must be screened again through the appropriate state licensing board(s), the FSMB (physicians only), and NPDB-HIPDB and complete the initial process. All information obtained through the credentialing process will be carefully considered before an employment and privileging decision is made.

1. Application Forms: Candidates seeking appointment or reappointment must complete appropriate forms for the position for which they are applying.

a. All candidates, requiring credentialing in accordance with this policy, must complete an electronic submission of VetPro. VetPro's supplemental information form requests applicants to answer TJC and VHA requirements. This supplemental information form requires the applicant to provide information concerning malpractice, adverse actions against licensure, privileges, hospital membership, research, etc.

b. The "Sign and Submit" screen in VetPro addresses the applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility to which the application is being made, as well as attesting to the accuracy and completeness of the information submitted.

c. An applicant is required to provide information on all educational, training, and employment experiences, including all gaps in the candidate's history.

d. If the delay between the candidate's application and 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 the candidate reporting for duty. Verification of a time-limited credential cannot be greater than 120 days old at the time a practitioner reports for duty. This requirement includes a response from the NPDB-HIPDB.

Note: Delays between the candidate's application and reporting for duty most frequently occur in the case of an individual for whom special waivers (i.e., visa waiver) may be required. Since these processes can be time consuming, information on the candidate's practice or non-practice during the period of the delay must be obtained in order to ensure the most appropriate placement of the candidate.

Note: A copy of the appropriate application form and any supplemental form(s) are maintained electronically in VetPro and may be filed in Section I of the credentialing and privileging folder. If the applicant provides a resume or curriculum vitae, this is also filed in Section I.

2. Licensure: As part of the credentialing process, the status of an applicant's licensure and that of any required or claimed certifications must be reviewed and primary source verified.

a. Requirement for Full, Active, Current and Unrestricted License:

1. Except as provided in VHA Handbook 5005, Part II, Chapter 3, subparagraph 14b, every VHA independent practitioner must have at least one current, full, active and unrestricted license to practice medicine, surgery, dentistry, psychology, or the administration of anesthetic agents in a state, territory, or commonwealth of the United States (i.e., Puerto Rico), or in the District of Columbia. If required by the state of licensure, current registration must also be maintained.

2. Applicants being credentialed for a position identified in 38 U.S.C. Section 740(b) (other than a Director) for whom State Licensure, registration, or certification is required and who possess or have possessed more than one license are subject to provisions as outlined in VHA Handbook 1100.19.

3. An independent practitioner's license is restricted if the state licensing board has suspended the licensee's ability to independently prescribe controlled substances or other drugs, selectively limited one's authority to prescribe a particular type or schedule of drugs, or accepted one's offer to voluntarily agree to limit authority to prescribe.

b. Appointment of Candidates with Previous or Current Adverse Action Involving Licensure: Independent practitioners who have a current unrestricted license in one or more states, but who have, or have ever had, a license restricted, suspended, limited, issued and/or replaced on probational status, or denied upon application, Maybe appointed under

the appointment procedures that applies to other physicians. In addition to the credentialing requirements for the position, there must be a complete review of the facts and circumstances concerning the action taken against the State License, registration, or certification and the impact of the action on the professional conduct of the applicant. This review must be documented in the licensure section of the credentials file.

1. If action was taken against the applicant's sole license, or against all the applicant's licenses, a review by the Chief, Human Resources Management Service, or Regional Counsel, is necessary to determine whether the applicant meets VA's licensure requirements. Documentation of this review must include the reason for the review, the rationale for conclusions reached, and the recommended action; all this must be filed in the Credentialing and Privileging folder and appropriate sections of VetPro.

2. Health care professionals who have a current, full and unrestricted license in one or more States, but who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review. Documentation of this review must include the reasons for the review, the rationale for the conclusions reached, and the recommended action. The review and the rationale for the conclusions must be forwarded to the VISN Chief Medical Officer for concurrence and approval of the appointment. All associated documentation must be filed in the Credentialing and Privileging folder and the appropriate section of VetPro.

- c. Verification with State Licensing Board(s): Verification can be made through a letter or by telephone and documented on a report of contact. Electronic means of verification are also acceptable as long as the site is maintained by the primary source and there is no disclaimer regarding authenticity. At the request of the Chief of Staff, the facility Director may delegate responsibility for contacting State Licensure Boards. If the State is unwilling to provide primary source verification of licensure, the facility must document the State's refusal and secure an authenticated copy of the license from the applicant.

- d. Federation of State Medical Board (FSMB) Screening: Physician applicants, including physician residents who function outside the scope of their training programs, will be screened with the FSMB prior to appointment. The screening with the FSMB must be performed through VetPro. Once education has been verified in VetPro, the query can be electronically submitted. Responses are received by VetPro and displayed on the License screen. The FSMB is a secondary information source; any reported information must be validated with the primary source; i.e., the state licensing board.

1. Appointment to the medical staff and granting of clinical privileges is not complete until screening against the FSMB Disciplinary Files is documented in VetPro. It will be documented in VetPro that information obtained through screening against the FSMB Disciplinary Files is verified through the primary source and that this information has been considered during the appointment process. If additional information is needed from the practitioner in response to this information, that will be obtained through, and documented in VetPro.

2. Those practitioners who were screened against the FSMB Disciplinary Files by VA Central Office in 2002, or subsequent to this date were screened

through VetPro, are placed in VHAs FSMB Disciplinary Alerts Service. Practitioners entered into the VHAs FSMB Disciplinary Alerts Service are continuously monitored. Orders reported to the FSMB from licensing entities, as well as the Department of Health and Human Services (DHHS) OIG and the Department of Defense (DOD), initiate an electronic alert that an action has been reported to VHAs Credentialing and Privileging Director. Alerts received by the Credentialing and Privileging Director must be forwarded to the appropriate VA facility for primary source verification and appropriate action. The disciplinary information that pertains to the practitioner can then be downloaded and forwarded to the appropriate facility for review and inclusion in the practitioner's credentials file. Practitioner names will be removed from the VHA FSMB Disciplinary Alerts Service when the practitioner file is inactivated in VetPro, or when the practitioner's appointment lapses in VetPro.

3. National Practitioner Data Bank (NPDB) - Healthcare Integrity and Protection Data Bank (HIPDB): NPDB-HIPDB screening is required for applicants, including physician residents who function outside of the scope of their training program, i.e. those appointed as Admitting Officer of the Day, all members of the medical staff and other health care professionals who hold clinical privileges. The information received in response to an NPDB-HIPDB query is to be considered together with other relevant data in evaluating a practitioner's credentials; it is intended to augment, not replace, traditional forms of credentials review. VetPro maintains evidence of query submission and response received, as well as any reports obtained in response to the query and meets the NPDB-HIPDB requirement. For those queries not done through VetPro, evidence of query submission will be retained in the Credentialing and Privileging file until receipt of the NPDB-HIPDB screening results.

NPDB-HIPDB screening is required:

- a. Prior to appointment, including reappointment and transfer from another VA facility, whether or not VA requires licensure for appointment, reappointment, or transfer;
- b. Every two years following appointment or reappointment; and
- c. Any time a clinical privilege application is made, including a request for additional privileges, regardless of the time since the previous NPDB-HIPDB query or privileges were granted. If the NPDB-HIPDB screen shows adverse action or malpractice reports, an evaluation of the circumstances and documentation thereof, is required. Questions regarding legal aspects of a particular case are to be directed to Regional Counsel. The facility Director is the authorized representative who authorizes all submission the NPDB-HIPDB.

4. Review of the Department of Health and Human Service Office of Inspector General as required by the Balanced Budget Act (BBA) of 1997 (Public Law 105-33): To ensure that VHA funds will not be paid to any entity or individual specifically excluded.

5. Pre-employment References: As a minimum, documented contact must be made with three references obtained from the applicant, including one from the current or most recent employer or institution where the applicant practiced or had privileges.

VA Form Letter 10-341a, Appraisal of Applicant, the reference letter printed from VetPro, or any other acceptable reference letter may be used to obtain references. All references must be documented in writing. Written records of telephone or personal contacts must include who was spoken to, that person's position and title, the date of the contact, a summary of the specific information provided the name of the organization, and the reason why a telephone or personal contact was made in lieu of a written communication. Information must be obtained relative to the scope and level of professional and clinical competence in the areas in which privileges are sought, health status, and fulfillment of responsibility as a member of the medical staff. A copy of the practitioners' currently held or most recently held clinical privileges and findings from the facility's Quality Management (QM) program including, but not limited to, number of procedures/surgeries performed, number and type of patients treated, mortality rate, and infection rates will be requested from the institution where privileges are held. If the applicant has prior VA or other Federal service, an effort will be made to obtain a reference from officials at the facility where the applicant was previously employed.

6. Health Status: Determination of the applicant's health status will include a self-declaration of appropriate health status by the applicant.

a. Initial Appointment: At the time of initial medical staff appointment, the practitioner's declaration of health statement must be confirmed by a physician designated by or acceptable to VA, such as the employee health physician or physician service/section chief. Confirmation, at a minimum, should be in the form of a countersignature by the confirming physician. The confirming physician may not be related to the applicant by blood or marriage.

b. Reappointment/Reappraisal: At the time of reappraisal the practitioner's declaration of health statement must be confirmed, by signature, by the COS or his designee, and/or section chief.

7. Verifying Specialty Board Certification: Prior to appointment, the COS will document evidence of certification by an American Specialty Board(s), if claimed by a physician or a Dental Specialty Board for dentists. The COS must personally cite the documentation and indicate that he/she has done so in the appropriate items on the employment application, VA Form 10-2850. Physicians' board certifications may be verified through the Official ABMS Directory of Board Certified Medical Specialists, published by the American Board of Medical Specialists, the Advisory Board for Osteopathic Specialists' Directory of Osteopathic Physicians and A.O.A. Approved Postdoctoral Training or direct communication with officials of the board in question or approved websites. Dentists' board certification may be confirmed by the listings in the American Dental Directory published annually by the American Dental Association or by contacting the appropriate Dental Specialty Board. If listings of specialists are used to verify board certification, these must be from current or recently issued copies of the above publications, with a certified copy of the cover page indicating publication date and a certified copy of the page listing the practitioner. Board certification(s) will be reviewed and documented prior to expiration, if applicable.

8. Malpractice Considerations: At the time of initial hire, a new appointment or reappraisal, each employee or returning practitioner must give details in writing of any involvement in administrative, professional, or judicial proceedings in which professional malpractice on their part is or was alleged. If an applicant has been involved in such

proceedings, a full evaluation of the circumstances will be made by officials participating in the credentialing, selection, and approval processes prior to making any recommendation or decision on the applicant's suitability for VA employment. Facility officials will evaluate the individual's explanation of specific circumstances in conjunction with the primary source information related to the payment in each case. This review will be documented and filed in section VI of the C&P folder and the appropriate section in VetPro. In cases where individuals meet criteria for higher level review, it will be documented VetPro. The evaluating officials will consider VA's obligations as a health care provider to exercise reasonable care in determining the applicants are properly qualified, recognizing that many allegations of malpractice are proven groundless.

9. Educational Credentials: Applicants are required to provide information on all education/training experiences including all gaps greater than thirty days in educational history. Applicants' educational credentials, which are used to qualify for employment and substantiate the clinical privileges being sought, will be verified with the primary source. Verification of educational credentials will include verification of professional education as well as residency and fellowship training. Primary source verification of other advanced educational/clinical practice program is required if the applicant offers this as a primary support for requested specialized clinical privileges. For graduates of foreign medical schools who possess an Educational Commission for Foreign Medical Graduates (ECFMG) certificate, primary source verification must be sought. ECFMG certification may be used as primary source verification for foreign medical graduates. Documentation of completion of a "Fifth Pathway" may be substituted for ECFMG certification. All efforts to verify education must be documented if it is not possible to verify education e.g., the school has closed, the school is in a foreign country and no response can be obtained or other reasons. In any case, facility officials must verify and document that candidates meet appropriate VA qualification standard educational requirements prior to appointment as an employee.

10. Drug Enforcement Administration (DEA) Registration: If applicable, applicant will be required to indicate on his/her employment application form information about his/her current or most recent DEA Certificate. In addition, any applicant whose DEA certification has ever been revoked, suspended, limited, restricted in any way, or voluntarily relinquished will be required to furnish written explanation when filing the employment application and at the time of reappraisal. A copy of the current DEA Certificate will be sighted prior to appointment and reappointment. DEA Certification must be verified, either by electronic means or an authenticated copy of the DEA certificate must be entered into VetPro and filed in the C&P folder. A report of contact is required documenting the reason(s) for non-renewal of a previously held DEA certification.

11. Transfer of Credentials: When practitioners are assigned to more than one health care facility for clinical practice, the primary or originating facility must convey all relevant credentials information to the gaining or satellite facility; this may be accomplished by forwarding an authenticated true copy to the C&P file to the receiving facility. The VetPro electronic credentials file must be shared with the gaining or satellite facility. A copy of the original employment application, VA Form 10-2850 or other appropriate appointment information needs to be provided to the gaining facility. *Note: The gaining facility must query the NPDB-HIPDB, obtain primary source verification of all active licenses, accept the transferred credentials, appoint the practitioner, and grant the appropriate clinical privileges before the practitioner can engage in patient care.*

12. Disposition of Credentialing and Privileging Files:

a. When a VA employee separates from VA employment, the C&P file will be retired to the Federal Records Center three years after the employee separates from VA employment. The Records Officer at each facility is responsible for advising on the disposition of records.

b. C&P files on applicants not selected for VA employment are to be destroyed two years after non-selection or when no longer needed for reference, whichever is sooner.

c. Credentialing folders may be thinned if they become unmanageable, but the backup material must be available in the facility.

d. When a VA practitioner transfers from one VA facility to another, the original C&P folder needs to be transferred to the gaining facility immediately upon transfer. This needs to be accomplished by a means that allows for tracking of the file through the transfer process, e.g., overnight mail or certified mail return receipt requested.

e. Electronic credentialing files in VetPro must be inactivated through the File Administration screen at the time of separation or non-selection.

13. Medical Staff Bylaws: Applicants must sign an agreement to abide by Medical Staff Bylaws requirements. Applicants will be expected to commit to providing continuous care to medical center patients.

C. Privileging:

1. General Provisions: Privileges granted to an applicant must be medical center specific and based on the procedures and types of services provided within this medical center. Thus, privileges should be requested for only those procedures, which the medical staff member will perform at this medical center. Each practitioner must be assigned to, and have clinical privileges in, one clinical service and may be granted privileges in other clinical services. Delineation of privileges are determined by the individual services, recommended by the Executive Committee of the Medical staff as defined in the Medical Staff Bylaws and approved by the facility Director. The exercise of clinical privileges within any service is subject to the policies and procedures of that service and the authority of that service chief. General criteria for privileging shall include the following: evidence of current license(s), relevant training and/or experience, current competence, health status, and peer recommendations; consideration of any information related to medical malpractice allegations or judgments, loss of medical staff membership, loss/reduction of clinical privileges, or challenges to licensure. Clinical Privileges are granted for a period not to exceed 2 years, which begins from the date the privileges are signed, dated and approved by the facility director. However, clinical privileges granted to contractors may not extend beyond the contract period. Each new contract period requires reappraisal and re-privileging. The process for the renewal of clinical privileges needs to be initiated no later than 2 or 3 months prior to the date the privileges expire.

2. Initial Privileges:

a. Clinical privileges requests must be initiated by the independent practitioner. For all practitioners desiring clinical privileges, the initial application for appointment must be accompanied by a separate request for the specific clinical privileges desired by the applicant.

b. The applicant's request for clinical privileges, as well as all credentials offered to support the requested privileges must be provided for review to the services chief responsible for that particular specialty area. The service chief will evaluate health status, past experience, training, clinical competence, judgment, clinical and technical skills, professional references, information from QM activities, and other appropriate information. The documentation of this review must include, at least, a list of the documents reviewed and the rationale for the conclusions.

c. The service chief recommends approval, disapproval, or a modification of the requested clinical privileges. This may include a limited period of direct supervision, or proctoring, by an appropriately-privileged practitioner for privileges when a practitioner has had a lapse in clinical activity, or for those procedures that are high risk.

d. Subsequent to the service chief's review and recommendation, the request for privileges, along with the appointment recommendation of the Professional Standards Board (PSB), must be submitted to the medical staff's Executive Committee for review. The medical staff's Executive Committee evaluates the applicant's credentials to determine if clinical competence is adequately demonstrated to support the granting of the requested privileges. Minutes must reflect the documents review and the rationale for the stated conclusion. A final recommendation is then submitted to the facility Director.

e. Copies of current clinical privileges must be available to hospital staff on a need-to-know basis in order to ensure providers are functioning within the scope of their clinical privileges.

f. A denial of initial privileges, for whatever reason, is not reportable to the NPDB. Where it is determined, for whatever reason that the initial application and request for clinical privileges should be denied, the credentialing file, and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. A "Do Not Appoint" screen must be completed in VetPro documenting the date of the decision.

3. Temporary Appointments and Privileges for Urgent Patient Care Needs:

a. The recommendation for temporary privileges will be made by the COS and approved by the Center Director. Temporary privileges should not exceed sixty calendar days.

b. Prior to appointment and privileging, evidence of current licensure verification, confirmation of possession of comparable clinical privileges, initiation of NPDB query, review of OIG exclusion sanction list, and one reference will be obtained. For physicians, FSMB screening will have been initiated prior to appointment, if at all possible, otherwise during the next working day.

4. Emergency Privileges during Disasters:

a. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, privileges may be granted by the Chief of Staff and/or the Center Director or their designee(s). Utilizing direct observations and record reviews with standardized triggers, the professional performance of volunteer providers granted disaster privileges will be monitored. Individuals granted emergency privileges during times of disaster will be identified through the hospital identification program. Privileges will be granted on a case-by-case basis after presentation of one of the following:

1. A current picture hospital identification card that clearly identifies professional designation;
2. A current license to practice;
3. Primary source verification of the license begins as soon as the immediate situation is under control, and is completed within seventy-two hours from the time the volunteer practitioner presents to the organization. Primary source verification of licensure will not be required if the volunteer does not provide care, treatment, and services under the disaster privileges.
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or groups.
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity.
6. Identification by current hospital or medical staff members who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.
7. Disaster privileges will not exceed ten calendar days or the length of the disaster, whichever is shorter. At the end of this period, the practitioner will be converted to temporary privileges or relieved.

5. Expedited Medical Staff Appointment:

a. All providers seeking expedited appointment must complete an application and documentation of credentials through VetPro. The Credentialing and Privileging section must verify all education/training. One active current unrestricted license must be verified by primary source. Current comparable privileges held in another institution must be verified. Two peer reference and a declaration of health must be confirmed. Queries for NPDB-HIPDB and FSMB must be completed and reviewed. The practitioner must be approved by the executive of the clinical service or care line.

b. An applicant is ineligible for the expedited process if at the time of appointment, or if since the time of reappointment, any of the following has occurred:

1. The applicant submits an incomplete application;
2. The MSEC makes a final recommendation that is adverse or with limitation;
3. There is a current challenge or a previously successful challenge to licensure or registration;
4. The applicant has received an involuntary termination of medical staff membership at another organization;
5. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges; or
6. There has been a final judgment adverse to the applicant in a professional liability action.

c. If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted, and there is no history of malpractice payment, the Professional Standard Board may recommend appointment to the medical staff. This recommendation will be acted upon by the facility Director. The forty-five calendar days for the completion of the full credentialing process begins with the date of the Director's signature. This is a one-time appointment process for initial appointment to the medical staff and may not exceed forty-five calendar days. It may not be extended or renewed. The complete appointment process must be completed within forty-five calendar days and presented to the Executive Committee for ratification or the medical staff appointment will automatically be terminated.

D. Reappraisal/Reprivileging:

1. Ongoing assessment and biennial reappraisal of each medical staff member and any other practitioner who holds clinical privileges is required. Reappraisal is initiated by the practitioner's service chief at the time of a request by the practitioner for new and renewed privileges. Reappraisal for renewal of clinical privileges must be conducted for each practitioner at least every two years.
2. Reprivileging is the renewal of clinical privileges and must be conducted at least every two years.
3. Reappraisal will include a review of professional performance, judgment, and clinical and/or technical competence and skills, an evaluation of the individual's physical and mental status, assessment of the individual's current privileges and will be based in part on results of quality management activities. On-going reviews conducted by service chiefs will include at minimum, when applicable, information from surgical case reviews, infection control reviews, medical record reviews, blood usage reviews, pharmacy and therapeutic reviews, drug usage evaluations, monitoring and evaluation of quality and appropriateness of care, and the clinical aspects of the risk management program.

4. The reappraisal/reprivileging process will include the verification of current medical licensure and Drug Enforcement Administration (DEA) registration; and the practitioner's statements regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction or loss of privileges at another medical center; loss of medical staff membership; pending malpractice claims; mental and physical status; and any other reasonable indicators of continuing qualifications. It also requires verification of satisfactory completion of sixteen hours of documented AMA Category I or II continuing education or the professional equivalent. Requests for renewal of privileges will be processed in the same manner as initial privileges. As an administrative responsibility, medical staff members must request renewal of privileges in a timely manner prior to the expiration date of current privileges.

5. The service chief will assess a minimum of two peer recommendations and all other information that addresses the professional performance, judgment, disciplinary actions, challenges to licensure, loss of medical staff membership, changes in clinical privileges at another medical center, involvement in any malpractice actions, and clinical and/or technical skills of the individual. The service chief must document that the results of quality assessment activities have been considered in recommending individual privileges and complete the "Service Chief's Approval" in VetPro. Upon completion of this assessment, the Service Chief makes a recommendation to the Clinical Executive Board (CEB) with the supporting documentation. The CEB will document their review and recommendation in the committee minutes and submit their recommendation to the facility Director for final action.

6. Because medical center practices and clinical techniques change over time, it is normal that clinical privileges would also change. The service chief will review with the practitioner the specific procedures and/or treatments that are being requested. Issues such as documented changes in the facility's mission, failure to perform a sufficient number of operations and/or procedures to maintain proficiency, or failure to use privileges previously granted will affect the service chief's recommendation for the granting of new privileges. These actions will be considered changes and will not be construed as a reduction, restriction, loss or revocation of clinical privileges. Such changes will be discussed between the service chief and the individual requesting renewal of privileges.

7. Practitioner may submit a request for modification of clinical privileges at any time. Requests to increase privileges must be accompanied by appropriate documentation which supports the practitioner's assertion of competence. The request must be made through VetPro, in addition to verifying all current credentials and competency associated with the request, active licenses must be verified and a query to the NPDB-HIPDB will be made. Following review, the service chief will make a recommendation to the medical staff's Executive Committee; which in turn, will present a recommendation to the facility Director for final action.

8. The granting of new clinical privileges for the COS will be the same as outlined in preceding paragraphs. The COS's request for privileges will be reviewed and a recommendation made by the relevant service chief responsible for the particular specialty area in which the privileges are requested.

9. Credentialing and Privileging for Telemedicine/ Teleconsultation. Practitioners providing only Teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located. The practitioner's credentials

must be shared with the facility receiving the Teleconsultation services using shared access of the VetPro file. When telemedicine services are being provided by the practitioner who directs, diagnoses, or otherwise provides clinical treatment to a patient via a telemedicine link, the practitioner must be appointed, credentialed, and privileged at the facility which receives the telemedicine services (patient site), as well as at the site providing the services. A separate delineation and granting of privileges must be made by the facility receiving the telemedicine services.

10. Denial and Non-renewal of Privileges. At the time of initial application and request for clinical privileges, if it determined for whatever reason that the application should be denied, the credentialing and privileging folder, and appropriate minutes must document that medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the committee and the facility Director. A "Do Not Appoint" screen must be completed in VetPro documenting the date of the decision, but this action is not reportable to the NPDB. If privileges are denied or not renewed based on facility resources, the records must document this reason as well. If the reason for denial or non-renewal is based on, and considered to be related to, professional misconduct or substandard care, the action must be documented as such and is reportable to the NPDB after appropriate internal due process procedures for reduction and revocation of privileges are provided.

E. Reduction and Revocation of Privileges:

1. Reduction of privileges may include, but not be limited to, restricting or prohibiting performance of specific procedures including 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. Revocation of privileges refers to the permanent loss of clinical privileges. If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures as outlined in Medical Staff Bylaws and VA regulations will be followed.

2. Any professional review action that adversely affects the clinical privileges of an independent practitioner for a period longer than 30 days; or any acceptance of the surrender of clinical privileges, or any restriction of such privileges by an independent practitioner either while the practitioner is under investigation by the medical center relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding; will be reported to the NPDB. Further information on the Reduction and Revocation of Privileges is found in medical Center Policy memorandum F-11P-34.

3. Clinical privileges may be summarily suspended when the failure to take such an action may result in an imminent danger to the health of any individual. Summary suspension pending comprehensive review and due process is not reportable to the NPDB. However, the notice of the summary suspension to the practitioner needs to include a notice that if a final action is taken, based on professional competence or professional conduct grounds, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. The notice of summary suspension will contain a notice to the individual of all due process rights.

a. When privileges are summarily suspended, the comprehensive review of the reason for summary suspension must be accomplished within 30 calendar days of the suspension with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to the facility Director for consideration and action. The Director will make a decision within 5 working days of receipt of the recommendations. The decision could be to exonerate the practitioner and return privileges to an active status or that there is sufficient evidence of improper professional conduct or incompetence to warrant proceeding with a reduction or revocation process.

NOTE: *Proceeding to the reduction or revocation process requires appropriate due process. Guidance should be sought from Regional Counsel and Human Resources to ensure due process is afforded. It is only after the due process is completed and a final action taken by the facility Director and all appeals have been exhausted that the summary suspension and subsequent reduction or revocation of clinical privileges of a physician or dentist is reported to the NPDB.*

b. If the practitioner's clinical privileges are pending renewal and due to expire during a summary suspension or due process procedures for reduction or revocation, the clinical privileges must be denied pending the outcome of the review and due process procedures. This denial is considered administrative until such time as a final decision is made in the summary suspension or due process procedures. The final decision determines whether an adverse action has occurred and the responsibility for reporting of the action. If the final action results in what would have been a reportable event, it must be reported in accordance with VHA Handbook 1100.17.

F. Deployment and/or Activation Privilege Status. In the instances where a provider is called to active duty, the provider's privileges are to be placed in a Deployment and/or Activation status. The credential files continue to remain active with the privileges in this new status. If at all possible, this process for returning privileges to an active status must be communicated to providers before deployment.

1. Providers returning from active duty must be asked to communicate with the medical center staff as soon as possible upon returning to the area.

2. The provider must update the electronic Credentials File in VetPro after the file has been reopened for credentialing, updating licensure information, health status and professional activities while on active duty.

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

4. The verified credentials, the practitioner's request for returning the privileges to an active status, and the service chief's recommendation are to be presented to the medical staff's Executive Committee for review and recommendation. The decision of the medical staff's Executive Committee must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and forwarded to the facility Director for recommendation and approval of restoring the provider's privileges to Current and Active status from Deployment and/or Activation status.

III. DEFINITIONS:

A. Independent Practitioner: An independent practitioner is any individual permitted by law (the statute which defines the terms and conditions of the practitioner's licenses) and the facility to provide patient care services independently; i.e., without supervision or direction, within the scope of the individual's license and in accordance with individually granted clinical privileges. This is also referred to as a licensed independent practitioner (LIP). **NOTE:** *Only LIPs may be granted clinical privileges.*

B. Active Medical Staff: Full-time, temporary full-time, and regular part-time (one-half time or more) physicians, dentists, psychologists, and podiatrists.

C. Adjunct Staff: Consultants, attendings, regular part-time (less than one-half time), WOC, contract, and intermittent staff physicians and dentists. Fee-basis staff should be appointed to provide a specific service or perform a specific procedure for the purpose of administering to a particular patient. He/she will not be eligible to vote or be appointed as a committee member of the medical staff.

D. Affiliate Staff: Independent practitioners other than physicians, dentists, psychologists, and podiatrists, i.e., non-voting practitioners, such as Certified Registered Nurse Anesthetists, Chiropractors, Physician Assistants, and Nurse Practitioners.

E. House Staff: The house staff shall consist of those individuals, who are graduates of medical, osteopathic, or dental schools, engaged in a formal program of post-graduate training and education at the G. V. (Sonny) Montgomery VA Medical Center Medical Center, with or without compensation.

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

G. Credentialing: Credentialing is the systematic process of verifying and reviewing the qualifications and health status of applicants for appointment, to ensure that they possess the required education, training, experience, physical and mental health, and skill to fulfill the requirements of the position and to support their requested clinical privileges.

H. Clinical Privileging: The term clinical privileging is defined as the process by which a practitioner, licensed for independent practice is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure. Clinical privileges are granted for a period not to exceed two years and will comply with JCAHO and VA standards. VetPro must be used for credentialing all providers who are granted clinical privileges or credentialed for other reasons.

I. Reappraisal: Reappraisal is the process of periodically evaluating the professional credentials, health, and clinical competence of practitioners who have been granted clinical privileges.

J. Primary Source Verification: Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be documented in the form of a letter, documented telephone contact, or secure electronic communication with the original source.

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

L. Authenticated Copy: The term “authenticated copy” means that each page of the document is a true copy of the original document; and each page is stamped “authenticated copy of original”, dated and signed by the person doing the certification. **NOTE:** Facsimile copies of the verification documents may not be used for final verification.

M. Current: The term “current” applies to the timeliness of the verification, and use for the credentialing and privileging process. No credential is current and no query of the FSMB or the National Practitioner Data Bank (NPDB) - Health Integrity and Protection Data Bank (HIPDB) is current if performed prior to submission of a complete application by the practitioner to include submission of a complete of VetPro. At the time of initial appointment, all credentials must be current within 180 days of submission of a complete application. For reappointment, all time-limited credentials must be current within 180 days of submission of the application for reappointment including peer appraisals, NPDB-HIPDB queries, and other credentials with expirations.

N. Verification of Identity: The verification of identity is a check-in process that authenticates the provider. It is to be accomplished before the provider delivers any patient care. This can be done through any form of photo identification from a trusted source - a driver's license, a photo ID from the affiliate where you can confirm the process used for authentication there, etc.

O. Proctoring: Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations. The proctor must have clinical privileges for the activity being performed, but must not be directly involved in the care the observed practitioner is delivering. Proctoring that requires a proctor 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, constitutes supervision. Such supervision may be a reduction of privileges.

P. Teleconsulting: Teleconsulting is 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 hands-on care is delivered at the site of the patient by a licensed independent health care provider.

Q. Telemedicine: Telemedicine is 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.

Note: A crucial consideration in making a distinction between consultation and care is that teleconsultation occurs when the consultant involved recommends diagnoses, treatments, etc., to the consulting provider requesting the consult, but does not actually write the orders or assume the care of the patient. IF the consultant diagnoses, writes orders, or assumes care in any way, this constitutes "care" and requires privileges. A Medical Staff appointment is required if the provider is entering documentation into the medical record, e.g., teleradiology, teledermatology, etc.

R. Professional Practice Evaluation. The Professional Practice of LIPs with clinical privileges with is evaluated according to criteria approved by the organized medical staff. The policy and procedures for Focus Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) are detailed in Center Policy Memorandum CPM-F-11Q-48 Medical Staff Focused and Ongoing Practice Evaluation.

IV. RESPONSIBILITY:

A. Center Director. The Center Director is ultimately responsible for credentialing and privileging. The Center Director, designated by the Under Secretary for Health as the Governing Body of the facility, is responsible for:

1. Ensuring the labor-management obligations are met prior to implementing a Credentialing and Privileging Program that involves Title 5 independent practitioners who are represented by a professional bargaining unit.
2. Ensuring facility policy, including Medical Staff Bylaws, Rules and Regulations, is consistent with VHA Handbook 1100.19.
3. Approving appointments of non-centralized medical staff members.
4. Nominating to the Under Secretary for Health candidates for centralized positions.
5. Approving clinical privileges for all Medical Staff members.
6. Assuring that review mechanisms, including appropriate quality management oversight, are in place.
7. Providing necessary resources to ensure effective and efficient compliance with C&P requirements.

B. Chief of Staff. The Chief of Staff is responsible for:

1. Maintenance of the credentialing and privileging process that satisfies the requirements of this document. This includes the establishment/maintenance of documentation to support the process. The COS must ensure that all health care professionals applying for clinical privileges agree to provide continuous care to the patients assigned to them and are provided a copy of, and agree to abide by the Medical Staff Bylaws, Rules, and Regulations, and ensuring that the Medical Staff Bylaws are consistent with VHA Handbook 1100.19 and other VHA policy related to Medical Staff Bylaws.

2. Recommending to Center Director action of Clinical Executive Board (CEB) findings and recommendations as to appointments, etc.

C. Service Chiefs. The Service Chief is responsible for:

1. Recommending the criteria for clinical privileges that are relevant to the care provided in the service;

2. Reviewing all credentials and requested clinical privileges, and for making recommendations regarding appointment and privileging action; and

3. A continuous surveillance of the professional performance of those who provide patient care services with delineated clinical privileges.

4. Assuring that approval is obtained from the COS for recruitment of physician vacancies.

5. Recommending candidates for appointment to the COS.

6. Assuring compliance with policy.

D. Applicant and Practitioner. Applicants and appointed practitioners must provide evidence of licensure, registration, certification, and/or other relevant credentials, for verification prior to appointment and throughout the appointment process, as requested. They must agree to accept the professional obligations delineated in the Medical Staff Bylaws, Rules and Regulations provided to them. They are responsible for keeping the VA apprised of anything that would adversely affect or otherwise limit their clinical privileges. Each Independent Practitioner is responsible for maintaining at least one current, full and unrestricted state professional license and assuring renewal of licensure prior to date of expiration. The renewal process may take several days or weeks, so it is important to initiate renewal action far enough in advance to assure an active unrestricted license is renewed and received prior to the date of expiration.

E. Chief, Human Resources Management Service (HMRS) is responsible for:

1. Assuring that all documents related to appointment are reviewed and are in compliance with VHA personnel requirements.

2. Assuring appropriate representation and guidance are provided to the Professional Standards Board (PSB). The Chief, HRMS effects appointments of all staff practitioners. Appointments will not be made until all necessary reviews have been made and approval obtained.

F. The CEB is responsible for: Reviewing recommendations of the PSB and making final recommendation to the Center Director regarding appointments and privileging.

G. The PSB is responsible for: Considering compiled information regarding independent practitioners' credentials and recommending to the CEB the acceptability of the candidate and privileges requested.

V. PROCEDURES:

A. Initial Appointment:

1. After identification of a candidate for appointment and discussion/concurrence are received from the COS, SERVICE CHIEFS WILL PREPARE AN EMPLOYMENT APPLICATION PACKAGE AND FORWARD IT TO THE COS. (**NOTE:** *Dental candidates are recruited through VACO. Names of qualified applicants are forwarded to this station for selection by management. The employment application and procedures are the same.*) The employment application package will be submitted in duplicate to the COS and contain the following:

- a. A memorandum from the service chief to the COS requesting and/or providing:
- Name of candidate
 - Position to be filled
 - Proposed effective date
 - Type of appointment (full-time, part-time, etc.)
 - Recommended grade and step
 - FTEE availability
 - Confirmation of UMC academic appointment status, if applicable
 - ECFMG number (if applicable)
 - Professional Standards Board
 - Other information; i.e., consultant/attending, number of visits, and funding availability
- b. SF-52, Request for Personnel Action, for staff appointments only. Once the SF-52 is signed, it is to be forwarded to HRMS (05).
- c. Applicant's completed application form.
- d. Supplemental information form signed by applicant.

NOTE: *Applicant must be given a copy of the current Medical Staff Bylaws*

[Careful attention to detail must be provided to assure that the application and supplemental information are properly completed by the applicant. Any information regarding malpractice considerations will be included in the employment application package. Where applicable, VA application forms require applicants to give details in writing on any involvement in administrative, professional, or judicial proceedings in which professional malpractice on their part is or was alleged. If any applicant has been involved in such proceedings, a full evaluation of the circumstances will be made by officials participating in the credentialing, selection, and

approval process prior to making any recommendation or decision on the applicant's suitability for VA employment.]

- e. Signed declaration of health statement by applicant.
- f. Copy of applicant's current DEA certificate, if applicable.
- g. Copy of applicant's current curriculum vitae.
- h. Applicant's request for clinical privileges and applicable clinical privilege list (i.e., internal medicine, general surgery, plastic surgery, dental, etc.) Applicants will not be appointed without this privilege request. Requests for clinical privileges must be initiated by the applicant and reviewed and recommended by the service chief responsible for the particular specialty area in which the privileges are requested. The service chief will recommend the appropriate level of initial privileges based on applicant's health status, past experience, training, clinical competence, etc.
- i. A signed release of information form to obtain copies of the practitioner's currently held or most recently held clinical privileges and findings from the facility's quality assurance program including, but not limited to, number of procedures/surgeries performed, number and types of patients treated, mortality rates, and infection rates.

2. Upon receipt of the employment application package by the Chief of Staff's Office, the C&P Program Specialist will establish a C&P folder and initiate the VetPro application process and the FSMB screening on those candidates seriously being considered for appointment. NOTE: The FSMB is a disciplinary information service and will report only those disciplinary actions resulting from formal action taken by reporting medical licensing and disciplinary boards or similar official sources. Requests to FSMB are processed through the Network Director's field office and will include the full name, date of birth, medical school attended, year of graduation from medical school, school code, and social security number. *(Note: FSMB screening may be started as soon as a serious candidate is identified and an authorization for release of information is signed by the applicant. The information needed to obtain FSMB screening is listed above and may be forwarded to the Chief of Staff's office before the employment application package.)* If the FSMB screen reveals evidence of disciplinary action in any state(s), the physician may be employed only with prior VACO approval.

3. The COS will arrange for the VA Deans Committee to consider the applicant for recommendation to the Center Director should the applicant need/desire a faculty teaching appointment or be considered as a clinical service chief, Associate Chief of Staff (ACOS) or COS.

4. The Chief of Staff's office and the appropriate services will obtain the following information and/or certificates:

- a. References
- b. Board Certification(s)
- c. Education verification

- d. DEA status
- e. Previous clinical privileges (or status of changes of privileges) from all institutions where the applicant previously held or currently holds privileges.
- f. Professional licensure for all states in which the applicant has ever held a license (verified with the appropriate state licensing board).
- g. Official Personnel Folder for an applicant with prior VA or federal service.
- h. Status of citizenship/non-citizen visa by documentation on OMB Form No. 1115-0136.
- i. Copy of a physical examination completed within the last 90 days (or may arrange for one) and a confirmed declaration of health form.

5. Upon receipt of the completed credentialing package, the COS will assure all documents have been obtained, including a signed statement from the applicant that Medical Staff Bylaws have been provided and the agreement to abide by them. Additionally, the COS will sign the employment application, where applicable, documenting evidence has been cited regarding full licensure, current registration, naturalized citizenship, visa, board certification, etc.

6. Prior to the PSB, certain information will be provided by the C&P Program Specialist to HRMS on all staff appointments. The documents to be provided to HRMS are:

- a. Original employment application signed by the COS, where applicable, as noted in paragraph 4A (5) above.
- b. Copy of Supplemental Information form signed by applicant.
- c. A copy of the applicant's current curriculum vitae.
- d. Original reference letters.
- e. A copy of the verification documentation on board certification(s) when applicable.

7. The PSB will not be convened until all required credentialing documents are complete and in order.

8. The PSB will review the candidate's credentials, complete the board action, and make a positive/negative recommendation to the CEB. The CEB will recommend appointment and privileging action to the Center Director. The Center Director will approve or disapprove these requests. This information will be conveyed to the applicant, and a copy of the approved privileges will be provided to the service chief and the applicant.

B. Reprivileging/Reappraisal:

1. Practitioners granted clinical privileges will be reappraised and repriviledged biennially or earlier, based on recommendations made by the CEB. Approximately three months prior to the reprivileging of the practitioner, the service will be notified by the Chief of Staff's office that the practitioner's reappraisal and reprivileging is due. The service will obtain the reappraisal documents on each individual practitioner and a current copy of the bylaws for each from the Chief of Staff's office.

2. Provider specific profiles containing quality outcome data will be developed as stated in CPM F-11Q-48 Medical Staff provider specific profiles and utilized by the appropriate clinical service chief during the reappraisal of each practitioner.

3. Upon completion of the verification process and receipt of the completed applicant documents, the service chief will forward the reappraisal portion of the credentials to the Chief of Staff's office.

4. The reappraisal and reprivileging of the practitioner will be processed through the service chief, the CEB and the Center Director in the same manner as the original privileging request.

C. Reporting Requirements: A-123 Report (VHA Directive 2001-076).

VI. REFERENCE:

- A. Medical Staff Bylaws
- B. Center Policy Memorandum F-11P-34, Reduction or Revocation of Clinical Privileges of Medical or Professional Staff
- C. VHA Handbook 1100.19; Credentialing and Privileging
- D. VHA Directive 10-89-83
- E. VHA Directive 2008-029, Maintaining Billable Provider Credential Information in the VISTA New Person File
- F. VHA Directive 2001-076, OMB Circular A-123 Management Accountability and Control
- G. Applicable Joint Commission standards

VII. RESCISSION: Center Policy Memorandum dated October 20, 2008

/s/

Joe D. Battle
Center Director

ATTACHMENTS:

- A. Standard (Six-Part) Credentialing and Privileging Folder
- B. Provider Credential Maintenance in new Person File

EXPIRATION DATE: December 31, 2015

RESPONSIBLE OFFICE: Chief of Staff (11)

STANDARD (SIX-PART) CREDENTIALING AND PRIVILEGING FOLDER

1. GENERAL PROVISIONS:

A. The credentialing and privileging (C&P) folder is the standard system for the establishment and maintenance of credentialing, privileging, and related documents. Other information related to appointment is located in the employee's Official Personnel Folder. The contents of the folder are based on requirements outlined in Veterans Health Administration (VHA) Handbook 1100.19, Credentialing and Privileging.

B. The Chief of Staff is responsible for maintenance of the Credentialing and Privileging system. The folder will be kept active as long as the practitioner is employed by the Department of Veterans Affairs (VA) facility, the practitioner transfers to another VA facility, the folder will transfer to the new employing location.

2. FORMAT AND/OR FILING SEQUENCE:

A. The model folder provided to all facilities by the Under Secretary for Health on April 9, 1991, represents a practitioner who has held appointment or been utilized to provide on-station patient care for more than two years. An appropriate C&P folder is to be established for each practitioner regardless of the length of service. The specific sections of the standard folder are identified as follows:

1. Section 1. Application and Reappraisal Information
2. Section 2. Clinical Privileges
3. Section 3. Professional Education and Training
4. Section 4. License(s)
5. Section 5. Professional Experience
6. Section 6. Other Practice Information

B. Sections 1 and 2 provide for a complete overview of the individual practitioner's qualifications, type of appointment, and clinical privileges. Sections 3 through 6 represent the support documents to the information presented in Sections 1 and 2. All documents are to be filed in the order specified.

PROVIDER CREDENTIAL MAINTENANCE IN NEW PERSON FILE

1. PURPOSE: To define the procedure and identify the parties responsible for accurate update and maintenance of billable clinical providers in the New Person File as outlined in VHA Directive 2008-029, Maintaining Provider Credential Information, in the Veterans Health Information Systems Technology Architecture (VistA) New Person File, and to ensure accurate billing and Veterans Equitable Resource Allocation (VERA).

2. POLICY: The New Person File update and maintenance requires a cross-functional process that includes the offices of Credentialing and Privileging (C&P); Human Resources Management (HRM); Medical Care Cost Recovery (MCCR); Pharmacy Service, and the Office of Information Technology (OIT), as outlined in VHA Directive 2008-029.

The C&P office will be responsible for updating and maintaining credential information in the New Person File on all billable providers. Information in the New Person File will be reviewed and corrections sent to the Program Specialist (PS) on a monthly basis. A verified report of New Person File will be sent to the Compliance Officer monthly.

The Veterans Health Administration (VHA) standardized credentials for billing contained in VHA Directive 2008-029 will be adhered to when updating and/or maintaining the New Person File.

Standardized credentials contained in VHA Directive 2008-029 will be used when populating the Degree field.

Only providers who have signed ADP security agreements and have been credentialed and privileged by this medical center will be given authorization to write electronic orders in CPRS.

3. DEFINITIONS:

A. The New Person File is the VistA file that lists all persons with computer access, which includes billable providers. Billable providers are licensed providers whose services can be billed to third party payers. A detailed listing can be found in VHA Directive 2008-029.

B. The Degree Field in the VistA New Person File is used to enter/record credential information.

4. RESPONSIBILITIES:

A. The Chief of Staff is responsible for ensuring that this policy is communicated to clinical services.

B. Clinical services are responsible for requesting computer access for providers in their services.

- C. OIT will make initial entries in the New Person File for the provider.
- D. The Clinical Application Coordinators (CACs) will enter the appropriate person class for the provider.
- E. Pharmacy Service will provide C&P staff with the names and information on fee-basis providers so C&P can enter and verify credential information and licensure.
- F. OIT is responsible for maintaining the New Person File, delegating appropriate menu options to staff, and notifying the PS when a new provider has been entered in the New Person File.
- H. The Compliance Officer is responsible for conducting semi-annual audits of the New Person File.

The PS establishes and maintains relevant records for physicians, dentists, optometrists, podiatrists, psychologists, physician assistants, licensed clinical social workers, and advance practice nurses. The Office of the Chief of Staff will provide the Compliance Officer with a listing of billable providers and assist the Compliance Officer in verifying information needed at the time of the audits.

5. REFERENCES:

VHA Directive 2008-029, Maintaining Billable Provider Credential Information in the VISTA New Person File
MCM-1 1-008, Credentialing and Privileging
Code of Federal Regulations Title 21, Section 1301.22

BYLAWS AND RULES of THE MEDICAL STAFF

Of

Veterans Health Administration (VHA)

**G. V. (SONNY) MONTGOMERY VA MEDICAL CENTER
JACKSON, MISSISSIPPI**

Adopted: 9/28/2012

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PREAMBLE

Whereas, G. V. (Sonny) Montgomery VA Medical Center (VAMC), Jackson, Mississippi, is a public medical center organized under the provisions of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA).

Whereas, its purpose is to provide acute hospital care, ambulatory care, home care and Community Living Center care to eligible beneficiaries, education, and research; and recognizing that the Medical Staff is responsible for the quality of care, treatment, & services delivered by practitioners credentialed and privileged through the medical staff process and accountable to the Governing Body for all aspects of that care, the Medical Staff practicing at the VAMC, Jackson, Mississippi, hereby organize themselves for self-governance in conformity with the laws, regulations, and policies governing VHA and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing VA and do not create any rights or liabilities not otherwise provided for in law or VA Regulations. These bylaws, rules, and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence

DEFINITIONS

- 1 **Medical Staff.** All physicians, dentists, and other fully licensed individuals permitted by law and the medical center to provide patient care services independently, that is, without supervision or direction. The Medical Staff is organized under three categories of membership known as the Active, Adjunct, and Affiliate Medical Staff.
 - A. **Active** members are those physicians, dentists, psychologists, and podiatrists who are appointed at least half time or more to the medical center.
 - B. **Adjunct** members are those appointment to the medical center is less than half time; as well as WOC, fee basis, contract, consultants and attendings.
 - C. **Affiliate** members are licensed practitioners other than physicians, dentists, psychologists, and podiatrists who are appointed under these Bylaws; i.e., non-voting practitioners, such as certified registered nurse anesthetists and nurse practitioners. The privileging process is used for affiliate members due to the scope and complexity of their clinical activities.
- 2 **Governing Body.** The term "Governing Body" refers to the Under Secretary for Health, the individual to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the VA Medical Center Director.
- 3 **Center Director.** The Center Director (Chief Executive Officer) is appointed by the Governing Body to act as its agent in the overall management of the medical center. The Center Director is assisted by the Chief of Staff, Clinical Executive Board and the Associate

Director.

- 4 **Clinical Executive Board (CEB).** This board serves and acts for the Medical Staff in intervals between Medical Staff meetings as defined in Article V, Section 5.02. This board is composed of members as defined in Article V, Section 5.02, with the Chief of Staff as chairperson.
- 5 **Professional Standards Board (PSB).** This board is composed of three physicians or other members of the medical staff as appropriate appointed by the Chief of Staff, and the Chief of Staff will serve as chairperson. The PSB reviews competency assessment, quality improvement/performance improvement data process, along with the practitioner's request for privileges. It also conducts special reviews assigned by the Chief of Staff (COS).
- 6 **Psychology Professional Standards Board (PPSB).** A board composed of three psychologists who hold clinical privileges for independent practice at this Medical Center will serve as a PPSB for reviewing competency for psychology practice along with the psychologist's request for privileges. The chief Psychologist serves as an ex officio member of the PPSB for these reviews. The results are forwarded to the PSB along with the service chief's recommendation for granting of privileges.
- 7 **Medical Center Management.** Consists of the Center Director; Chief of Staff; Associate Director; Associate Director of Patient Care Services and other administrative staff members as may be required and requested by the Center Director.
- 8 **Deans Committee.** Committee established by a formal memorandum of affiliation between this medical center and medical and dental schools of the University of Mississippi, and approved by the Under Secretary for Health; composed of deans and senior faculty members of the University's medical and dental schools, representatives of the medical/dental staff of the medical center; and such other faculty of the University's schools and staff of the facility, including the Associate Director of Patient Care Services, as appropriate, to consider and advise on development, management, and evaluation of all VAMC educational programs conducted at the facility.
- 9 **Practitioner.** Any physician with an unlimited license, appropriately licensed dentist, or other appropriately licensed individual who provides patient care services independently; that is, without supervision.
- 10 **Appointment.** As used in this document the term refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority for providing patient care services at the facility. Both VA employees and contractors may receive appointments to the Medical Staff.
- 11 **Rules.** Refers to the specific rules set forth in this document, which govern the Medical Staff of the medical center. It does not refer to formally promulgated VA Regulations.

- 12 **Verification.** Verification is defined as primary source documentation by letter, telephone call, computer printout, or in the case of confirmation of board certification, by listing in specific directories. (See VHA policies on credentialing and privileging of physicians and dentists, and VA Directive 5021)
- 13 **Gender.** Any reference to gender in these Bylaws and Rules, "he" or "she" shall be applicable to both sexes.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi.

ARTICLE II. PURPOSE

- 1 The purpose of the Medical Staff is to develop, approve, and amend as necessary medical staff by-laws and rules, and to:
- 2 Ensure that every patient admitted to or treated by any service of this medical center shall receive safe, efficient, timely, and appropriate care, treatment, and services that is subjected to continuous quality improvement practices.
- 3 Ensure that all patients being treated for the same health problem or with the same methods/procedures receive the same level of care.
- 4 Establish and ensure adherence to ethical standards of professional practice and conduct.
- 5 Ensure ongoing evaluation of the competency of practitioners who are privileged, delineate the scope of privileges that will be granted to practitioners, and provide leadership in performance improvement activities within the organization.
- 6 Select and remove medical staff officers.
- 7 Determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges.
- 8 Provide an appropriate research and educational setting which will maintain scientific standards; lead to continuous advancement in professional knowledge and skills; and which will relate to patient needs, care provided, and the findings of quality care review activities.
- 9 Bring the deliberations of the Medical Staff to the Center Director and the Governing Body.
- 10 Develop and adhere to specific facility mechanisms for appointment to the Medical Staff and

delineation of clinical privileges.

- 11 Approve and amend the medical staff bylaws and provide oversight for the quality of care, treatment, and services provided by practitioners with privileges.
- 12 Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 3.01 Eligibility for Membership on the Medical Staff

1. Membership: Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent physicians, dentists, psychologists, and podiatrists who continuously meet the qualifications, standards, and requirements of VHA, this medical center, and these Bylaws. Membership may be considered for other licensed practitioners who are permitted by law to provide patient care services independently and who meet the qualifications, standards, and requirements of VHA, this medical center, and these Bylaws.
2. Categories of Medical Staff membership include:
 - A. Active: Physicians, dentists, psychologists, and podiatrists on a full-time, temporary full-time, and regular part-time (one-half time or more).
 - B. Adjunct: Consultants, attendings, WOC, regular part-time (less than one-half time), intermittent and on-station fee-basis, contract, and sharing agreement physicians, dentists, psychologists, and podiatrists. Fee-basis staff shall be appointed to provide a specific service or perform a specific procedure for the purpose of administering to a particular patient. He will not be eligible to vote or be appointed as a committee member of the Clinical Executive Board.
 - C. Affiliate: Licensed practitioners other than physicians, dentists, psychologists, and podiatrists who are appointed under these Bylaws; i.e., non-voting practitioners, such as certified registered nurse anesthetists and nurse practitioners. The credentialing and privileging process is used for affiliate members due to the scope and complexity of their clinical activities.
3. Decisions regarding Medical Staff membership are made without discrimination based on race, creed, color, religion, national origin, sex, lawful partisan political affiliation, marital status, physical or mental handicap when the individual is qualified to do the work, age, membership or non-membership in a labor organization, or on the basis of any other criteria unrelated to professional qualifications.

Section 3.02 Qualifications for Medical Staff Membership and Clinical Privileges

To qualify for Medical Staff membership and clinical privileges, individuals who meet the

eligibility requirements identified in Section 3.01 must submit evidence of:

1. Picture ID
2. Active, current, full, and unrestricted license to practice individual's profession in a State, Territory, or Commonwealth of the U.S. or the District of Columbia as required by VA employment and utilization policies and procedures. Individuals not licensed to practice in any state or the District of Columbia may be appointed members under the provisions of 38 USC 7407. The Under Secretary for Health or his designee may waive the licensure requirements of an individual solely in research or academic activities or in other positions where there is no direct responsibility for patient care. Psychologists may be given appointments as VA employees for up to two years prior to obtaining licensure. Unlicensed psychologists providing clinical services will work under the supervision of the licensed psychologists with clinical privileges and will not be granted privileges or membership in the Medical Staff.
3. Appropriate education; i.e., hold a Doctoral Degree in the discipline in which the individual is licensed to practice from an approved college or university.
4. Relevant training and/or experience, consistent with the individual's professional assignment and privileges for which applying. This includes any internships, residencies, board certification, or specialty training.
5. Current competence, consistent with the individual's assignment and the privileges for which he is applying. This process may include an assessment for proficiency in the six areas of general competencies (see section 3.03).
6. Health status consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within the clinical privileges granted.
7. Complete information consistent with requirements for application and clinical privileges as defined in Article VII or VIII these Bylaws for a position for which the medical center has the patient care need, adequate facilities, support services, and staff.
8. Satisfactory findings relative to previous professional competence and professional conduct.
9. English language proficiency.
10. Current professional liability insurance as required by Federal and VA acquisition regulations (for those individuals providing service under contract).
11. Ability to meet response time criteria established for the service or position for which he is applying.

NOTE: Individuals appointed to the medical center whose duties are administrative in nature only, with no clinical duties, are subject to the regular personnel policies of the

medical center. Those whose duties are administrative and include clinical responsibilities with the Medical Staff must obtain clinical privileges by the same procedure as provided in these Medical Staff Bylaws.

Section 3.03 Core Competencies

Experience, ability, and current competence in performing the requested privilege(s) are verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment, for proficiency in the following six areas of "general competencies"

1. **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
2. **Medical/Clinical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
3. **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
4. **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
5. **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.
6. **Systems-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

Section 3.04 Basic Responsibilities, Ethics and Ethical Relationships

The organized Medical Staff (and others with individual clinical privileges) are accountable for and have responsibility to:

1. Provide for continuous care of patients assigned to their care.
2. Observe patients' rights in all patient care activities and consider their psychosocial, cultural, and religious preferences when providing care.
3. Provide oversight in the process of analyzing and improving patient satisfaction.

4. Provide leadership role in organization performance improvement and patient safety activities.
 - A. To ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the medical staff provides leadership and is actively involved in the measurement, assessment, and improvement of, but not limited to, the following:
 - i) Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process.
 - ii) Medical assessment and treatment of patients
 - iii) Use of medications
 - iv) Use of blood and blood components
 - v) Use of operative and other procedures
 - vi) Appropriateness of clinical practice patterns
 - vii) Significant departure from established patterns of clinical practice through peer review
 - viii) Use of developed criteria for autopsies
 - B. To ensure that the medical staff participates in the measurement, assessment, and improvement of other patient care processes including, but not limited to the following:
 - i) Education of patients and families.
 - ii) Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient
 - ii) Accurate, timely and legible completion of patient's medical records.
 - C. To ensure that when the finding of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing evaluation of a licensed independent practitioner's competence, in accordance with the standards on renewing or revising clinical privileges.
 - D. To ensure that the findings, conclusions, recommendations, and actions taken to improve organizational performance are communicated to appropriate medical staff members. This information will include sentinel event data and other patient safety data as appropriate.
5. Maintain standards of ethics and ethical relationships including a commitment to:
 - A. Abide by Federal Law and VA Rules and Regulations regarding financial conflict of interest and outside professional activities for remuneration.
 - B. Provide care to patients within the scope of privileges and advise the Center Director, through the Chief of Staff, of any change in ability to meet fully the criteria for Medical Staff membership or to carry out clinical privileges which are held.

- C. Advise the Center Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence, or professional conduct within 15 calendar days of notification of such occurrences and their outcome consistent with requirements under Article VII of these Bylaws.
 - D. Contribute to and abide by high standards of ethics in professional practice and conduct.
- 6. Enforces and complies with the Medical Staff Bylaws and Rules and all other lawful standards and policies of the medical center and Veterans Health Administration.
 - 7. No full-time VA members of the Medical Staff may render professional service for remuneration to any patient hospitalized or treated at VA expense in a non-VA hospital, clinic, or other health facility. A full-time staff who engages in outside professional activities for remuneration must scrupulously avoid creating any situation or circumstances where it might be implied that the employee, because of his outside activity, is not meeting the full requirements and responsibilities of his VA position. Consequently, VA staff members who engage in outside professional activities for remuneration will be required to:
 - A. Perform a scheduled tour of duty of 80 hours per pay period while so involved.
 - B. Meet other patient care needs, which require their attendance beyond the scheduled tour of duty.
 - 8. Be responsible for planning and implementing a privileging process.

ARTICLE IV. ORGANIZATION OF THE MEDICAL STAFF

Section 4.01 Leaders

- 1. The medical staff shall elect a President, Vice President, and Secretary from among active members of the medical staff. The individuals will serve a term of 2 years. Any active member of the medical staff, who has been a member for a minimum of two years, will be eligible to hold office. Nominations for the positions will come from a nominating committee composed of the current officers of the medical staff, and elected at large members of CEB, or from open nominations from the floor prior to the election process. Elections for the positions will be held at the quarterly meeting of the medical staff, which falls closest to the conclusion of the term of office of the sitting officers.
- 2. At the completion of the president's term, the vice president shall succeed to the president in office. The secretary shall likewise succeed the vice president. Should an officer leave office prior to the end of his/her term, the subordinate officer shall advance and assume the completion of the term of that office, and a special election held to fill the term of the advancing officer. This would allow for the smooth transition of medical staff leadership, provide continuity of experience, and encourage a closer working relationship between the officers.

3. Elected officers of the medical staff may be removed from office by:
 - A. Failure to maintain membership of the active medical staff
 - B. By two-thirds majority vote of the medical staff for failure to fulfill his/her responsibilities, malfeasance in office, physical and mental infirmity to a degree which renders him/her incapable of fulfilling the duties or conduct detrimental to the medical center.

Section 4.02 Leadership

1. The President of the Medical Staff, or his designee, will act as Chairperson at all regular or special meetings of the full medical staff.
2. The active medical staff shall elect four at-large members to the Clinical Executive Board by written ballot every two years. All active Medical Staff members are eligible for membership on the CEB as a representative at large. Each at-large member of the Medical Staff may be removed from office by:
 - A. Failure to maintain membership of the active staff.
 - B. By a 2/3 majority vote of the medical staff for failure to fulfill his/her responsibilities, malfeasance in office, physical or mental infirmity to a degree which renders him/her incapable of fulfilling the duties of his/her office, or conduct detrimental to the Medical Staff.
3. The Medical Staff, through its officers, committees, services, and service chiefs, provides counsel and assistance to the Chief of Staff and Center Director regarding all facets of the patient care services program; including performance improvement, goals, plans, mission, and services offered.

Section 4.03 Clinical Services

1. The chief of the service to which the applicant is to be assigned is responsible for recommending appointment to the Medical Staff based on:
 - A. Evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.
 - B. Recommendations by the UMC departmental Chairperson will be considered, where applicable.
2. The CEB recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
3. A Professional Standards Board (PSB) will be held within 30 days of receipt of all verified information. The PSB is a subcommittee of the Clinical Executive Board (CEB). The Board

is composed of a minimum of three members one of whom is the Chief of Staff who serves as Chair. The PSB will review the applicant's credentials and will recommend approval/disapproval of Medical Staff membership.

4. Application for Medical Staff membership will normally be acted on by the CEB during the first board meeting following receipt of recommendations of the PSB. Based upon CEB recommendations, the Center Director will appoint or reject the applicant. Due process of rejected applicants is provided in accordance with Federal Regulations as outlined in VA Directive 5977 Equal Employment Opportunity Discrimination Complaints Process.
5. Appointments to the Medical Staff should be acted upon by the Center Director within 45 days of receipt of a complete application including all required verifications, references and recommendations from the appropriate service chief, PSB, and CEB.
6. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment within 10 days of an action by the Center Director. In the case that appointment is not approved, reasons will be provided.
7. Temporary Appointments and Privileges in Emergency Situations:
 - A. The recommendation for temporary privileges will be made by the COS and approved by the Center Director. Temporary privileges should not exceed 60 calendar days.
 - B. To appointment and privileging, verification of the following must be made:
 - Current Licensure
 - Relevant training or experience
 - Current competence
 - Ability to perform the privileges requested
 - Other criteria required by the organized medical staff bylaws
 - A query and evaluation of the NPDB information
 - A complete application
 - No current or previously successful challenge to licensure or registration
 - No subjection to involuntary termination of medical staff membership at another organization
 - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
8. Emergency Privileges During Disasters:
 - A. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, privileges may be granted by the Chief of Staff and/or the Center Director or their designee(s). Utilizing direct observations and record reviews with standardized triggers, the professional performance of volunteer providers granted disaster privileges will be monitored and overseen by the

medical staff. Individuals granted emergency privileges during times of disaster will be identified through the hospital identification program. Privileges will be granted on a case-by-case basis after presentation valid government-issued photo identification, issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current picture hospital identification card that clearly identifies professional designation
 - A current license to practice.
 - Primary source verification of the license begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. **NOTE:** In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges .
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or groups.
 - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
 - Identification by current hospital or medical staff members(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster .
- B. The Chief of Staff and/or the Center Director or their designee(s) will decide within 72 hours if the disaster privileges initially granted a practitioner will continue. The decision will be based on information obtained regarding the profession practice of the volunteer.
- C. Disaster privileges will not exceed 10 calendar days or the length of the disaster, whichever is shorter. At the end of this period, the practitioner will be converted to temporary privileges or relieved.
9. Expedited Appointment: The Credentialing process for an expedited appointment cannot begin until the licensed independent provider completes the credentials package including but not limited to a complete application; therefore the provider must submit this information through VetPro and documentation of credentials must also be retained in VetPro. **Note: VetPro is VHAs electronic credentialing system and must be used for credentialing all providers who are granted clinical privileges or credentialed for other reasons.**

To expedite the appointment of a provider, the Credentialing and Privileging Section must verify all of the education and training, one active current unrestricted license verified by primary source, current comparable privileges held in another institution, confirm two peer references, confirm the declaration of health, query *NPDB-HIPDB*, query *FSMB*, and have the executive of the clinical service, or care line approval.

- A. An applicant is ineligible for the expedited process if at the time of appointment any of the following has occurred:
 - i) The applicant submits an incomplete application;
 - ii) The Clinical Executive Board makes a final recommendation that is adverse or with limitation
 - iii) There is a current challenge or a previously successful challenge to licensure or registration;
 - iv) The applicant has received an involuntary termination of medical staff membership at another organization;
 - v) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;
 - vi) There has been a final judgment adverse to the applicant in a professional liability action.

- B. If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted, and there is no history of malpractice payment, the delegated Professional Standard Board may recommend appointment to the medical staff. This recommendation, by the Professional Standard Board, will be acted upon by the Medical Center Director. Full credentialing must be completed within 30 workdays and presented to the Clinical Executive Board for ratification. This is a one-time appointment process for initial appointment to the medical staff and may not exceed 45 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 45 calendar days of the Expedited Appointment or the medical staff appointment is automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director even though ratification of the appointment is accomplished within 45 calendar days (the effective date does not change).

Section 4.04 Professional Services

1. Organization and Characteristics of Services

- A. The Center Director is responsible for the proper and efficient management of the hospital.

- B. The Chief of Staff is directly responsible to the Center Director for the direction and coordination of patient care, and for research and education activities of the hospital.
- C. Each service shall be organized as a component of the staff as a whole and carry out services under the leadership of a service chief that will be responsible to the Chief of Staff for the functioning of his service.
- D. The staff of each service shall meet at least every other month, but such meetings shall not release members from their obligation to attend general meetings as provided in Article V of these Bylaws. The staff of each service will participate in prioritization of performance improvement activities, evaluating data, and developing and assessing actions which will be reported in staff meetings and followed up as necessary. Minutes of these meetings will be forwarded to each staff member and the Chief of Staff for review by the CEB. Attendance is required at monthly meetings by all regularly scheduled physicians on the service unless excused for justifiable cause by the service chief.

2. Clinical Services

A. Bed Services:

- i) Medical Service
- ii) Surgical Service
- iii) Neurology Service
- iv) Mental Health Product Line

B. Other Services:

- i) Anesthesiology Service
- ii) Dental Service
- iii) Pathology & Laboratory Medicine Service
- iv) Office of Education
- v) Nursing Service
- vi) Prosthetics and Sensory Aids Service
- vii) Radiation Therapy Service
- viii) Radiology Service
- ix) Physical Medicine & Rehabilitation Service

3. Ambulatory Care

The Chief, Medical Service is responsible for the direct supervision of the admissions office functions. The Chief of Staff will be responsible for the administrative components of the ambulatory care program, including fee services, compensation and pension examinations, and employee health. Service chiefs are responsible for the operation of their outpatient clinics.

4. Community Living Center Care

The Nursing Home Care Program is under the general clinical supervision of the Chief of Staff and the direct supervision of an assigned staff physician. Administrative and professional activities in the area are carried out by an interdisciplinary team.

5. Home Care

The Home Care Program is under the general clinical supervision of the Chief, Medical Service and the direct clinical supervision of assigned staff physicians. The program includes home based primary care and durable medical equipment which includes home oxygen. Administrative and professional activities in each program are carried out by interdisciplinary team.

6. Functions of Services

- A. Provide for continuous quality improvement within the service, including: considering findings of ongoing monitoring and evaluation of quality (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 initiatives; risk management activities; and utilization management.
- B. Assist in identification of important aspects of care for the service, identification of indicators used to monitor quality and appropriateness of important aspects of care, and evaluation of the quality and appropriateness of care.
- C. Maintain records of meetings that include conclusions, recommendations, actions taken, and evaluation of the effectiveness of actions taken.
- D. Develop criteria for and recommend to the medical staff clinical privileges for each member of its department.
- E. Define/develop clinical privileges statements including levels or categories of care that are to be provided.
- F. Develop policies and procedures to assure effective management, ethics, safety, and communications within the service.

7. Selection and Appointment of Service Chiefs

Service chiefs are appointed by VA Central Office on the recommendation of the Center Director. The Center Director will seek recommendation from the Chief of Staff. Board certification or certification of competence is required for service chiefs.

8. Duties and Responsibilities of Service Chiefs

- A. In addition to the functions of his service (see paragraph 6 above), service chiefs are responsible and accountable for:
- i) All clinically related activities of the service.
 - ii) All administratively related activities of the service, unless otherwise provided by the medical center.
 - iii) The integration of the service into the primary functions of the organization.
 - iv) The coordination and integration of interdepartmental and intradepartmental services.
 - v) The development and implementation of policies and procedures that guide and support the provision of care treatment and services.
 - vi) The recommendations for a sufficient number of qualified and competent persons to provide treatment care/service.
 - vii) Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the service.
 - viii) Recommending to the medical staff the criteria for clinical privileges in the service.
 - ix) Recommending clinical privileges for each member of the service.
 - x) The determination of the qualifications and competence of service personnel who are not licensed independent practitioners and who provide patient care service.
 - xi) The continuous assessment and improvement of the quality of care and services provided.
 - xii) The maintenance of quality control programs, as appropriate.
 - xiii) The orientation and continuing education of all persons in the service.
 - xiv) Recommendations for space and other resources needed by the service.
 - xv) The service chief's assessment and recommendations to the relevant medical center authority off-site sources for needed patient care services not provided by the service or the organization.
 - xvi) Enforcement of the Medical Staff Bylaws and other rules and regulations required by VA.
 - xvii) Implementation, within his service, of actions taken by the CEB and other policies

presented by the medical center and/or VA.

xviii) Supervision and support of education and research programs within his service.
Representing the interest of VA in affiliated educational and research programs.

ixx) Assessing and recommending to the governing body off-site sources of needed patient care, treatment, and services not provided by the department.

ARTICLE V. MEDICAL STAFF COMMITTEES

Section 5.01 General

All facility committees and committee members shall be appointed by the Center Director in accordance with VA Regulations and as outlined and defined in M-1, Part I, Chapter 1, Change 16 and Medical Center Policy EBGB 00-00 Executive Board of Governing Body.

Section 5.02 Executive Committee of the Medical Staff

1. Membership. The CEB is chaired by the Chief of Staff and is composed of the following:
 - A. President of the Medical Staff
 - B. Bed Service Chiefs (Medical, Surgical, Neurology and Mental Health)
 - C. Chief, Dental Service
 - D. Chief, Psychology Service
 - E. Chief, Pathology & Laboratory Medicine Service
 - F. Members-at-Large (4) (to be elected from & by the active Medical Staff members, to serve for a 2 year period)
 - G. Associate Director of Patient Care Services - Ex-Officio, non-voting
 - H. Center Director - Ex-Officio, non-voting
 - I. Nurse Practitioner – Ex-officio, non-voting (to be elected by NP members of the medical staff)
 - J. AA/Chief of Staff - Ex-Officio, non-voting
 - K. Chief, Office of Quality Management - Ex-Officio, non-voting
 - L. Patient Safety Manager, Ex-Officio, non-voting
 - M. Coordinator, Credentialing & Privileging, Ex-officio, non-voting

***Joint Commission specifies that the majority of the voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital.
2. Functions. The CEB functions as an authorized Executive Committee of the Medical Staff. It serves and acts on behalf of the organized Medical Staff between Medical staff meetings. The CEB reports to and is accountable to the organized Medical Staff and the Executive Board of the Governing Body (EBGB). The CEB had the primary authority for activities related to self-governance of the medical staff, for performance of the professional services

provided by licensed independent practitioners and other practitioners privileged through the medical staff process, and quality oversight of measurement, assessment and improvement of all areas mandated by Joint Commission and VHA policy.

- A. Coordinates the medical activities of the medical center; evaluates the quality of patient care services provided by the Medical Staff; and recommends necessary policies and procedures to the Center Director to assure compliance with appropriate professional standards of medical care, applicable VA regulations and Joint Commission requirements.
- B. Receives and acts on reports and recommendations from Medical Staff and hospital committees or services and functions under its purview. The CEB initiates appropriate follow-up actions.
- C. Acts on behalf of the Medical Staff between Medical Staff meetings.
- D. Acts to ensure effective communication between the Medical Staff and the Center Director.
- E. Independently makes recommendations directly to the Executive Board of the Governing Body (EBGB) regarding the:
 - i) Structure of Medical Staff.
 - ii) Mechanisms used to review credentials and delineate clinical privileges.
 - iii) Recommendation of individuals for Medical Staff membership.
 - iv) Delineation of privileges of each practitioner privileged through the medical staff process.
 - v) Recommendations for delineated clinical privileges for each eligible individual.
 - vi) Receives acts on, and approves reports and recommendations from medical staff committees, clinical departments, and assigned activity groups.
 - vii) Organization of quality improvement activities of the Medical Staff as well as mechanism used to conduct, evaluate, and revise such activities.
 - viii) Termination actions will be conducted in accord with VHA requirements as specified in VA Directive 5021 "Employee/Management Relations."
 - ix) Mechanisms for fair-hearings procedures as outlined in Directive 5021 "Employee/Management Relations."

- x) Medical Staff ethics and self-governance actions.
- F. Receives, acts on, and approves criteria for credentialing and granting clinical privileges for each service.
- G. Requests and reviews evaluations of practitioners privileged through the medical staff process instances where there is doubt about an applicant's ability to perform the privileges requested.

Section 5.03 Committees of the Medical Staff

1. **Professional Standards Boards (PSB)** This board is composed of three physicians or other professionals, as appropriate appointed by the Chief of Staff, and the Chief of Staff will serve as Chairperson. The PSB reviews applications for appointment and all other personnel applications requiring an appraisal of professional qualifications and performance. It also conducts special reviews assigned by the Chief of Staff or Center Director. (VHA Human Resources 5000 series.)
2. **Standing Committees.** Appropriate committees will be established to ensure accomplishment of the mandatory functional reviews described in M-1, Part I, Chapter 1.85. The following committees and boards are mandatory:
 - A. Clinical Executive Board
 - B. Professional Standards Board
 - C. Resident Review Boards
 - D. Utilization Review
 - E. Clinical Applications Resource Group (CARG) performs medical records committee function
 - F. Pharmacy and Therapeutics
 - G. Blood Usage Review
 - H. Operative and Invasive Procedure
 - I. Infection Control
 - J. Research and Development
 - K. Education
 - L. Cancer
 - M. Safety, Occupational Health, & Fire Protection
 - N. Ethics
 - O. Disaster Planning
 - P. Intensive Care Unit Committees

Section 5.04 Committee Records and Minutes

Committees prepare and maintain reports of actions taken to improve performance. The effectiveness of actions taken is evaluated. These reports are to be forwarded in a timely manner, normally within two weeks of the meeting.

Committees will provide for timely feedback to appropriate services any information for their use.

Section 5.05 Committee Attendance

Medical Staff members, or their designated alternates, will attend meetings of committees of which they are members unless specifically excused by the committee chairperson for appropriate reasons; e.g., illness, leave, clinical requirements, etc. Committee minutes will specify members present.

ARTICLE VI. MEDICAL STAFF MEETINGS

Section 6.01 Medical Staff Meetings

1. Quarterly meetings of the Medical Staff will be held at the call of the President of the Medical Staff. The agenda shall consist of medical and business portions.
2. Special meetings may be called at any time by the Center Director, Chief of Staff, or President of the Medical Staff. The President of the Medical Staff, within five days after receipt of a written request for same, signed by not less than 12½% of the medical staff and stating the purpose of such meeting, shall set a date for a special meeting. The President of the Medical Staff shall designate the time and place of any special meeting. Notice of the special meeting, including its date, time, and location, shall be delivered either personally or by mail (electronic or campus) to each member of the medical staff not less than 10 days prior to the meeting date. No business shall be transacted at any special meeting, except that stated in the notice calling the meeting.
3. Attendance is mandatory at service staff meetings and committees of which the individual is a member, as accepted below. Medical Staff members will attend at least one meeting of the Medical Staff as a whole, annually, unless specifically excused by the chairperson.
 - A. Except when: specifically excused by the service chief or Chief of Staff for appropriate reasons; e.g., illness, leave, or emergency clinical requirements.
 - B. All meetings of the Medical Staff will be open to active and adjunct members.
4. Voting privileges will reside with active members only.
5. A quorum will consist of one-half (1/2) of the members of the active staff.
6. Agenda will include:
 - A. Reports by Medical Staff Committees, as appropriate.
 - B. Quality of Care issues, including opportunities for improvement.

- C. Such other business as required for the functioning of the Medical Staff.
- g. Minutes of all meetings will reflect, at minimum, attendance, issues discussed, conclusions, actions, recommendations, effectiveness of actions taken and follow-up.

Section 6.02 Director's Staff Meeting

The Center Director, in order to maintain communications with both professional and administrative personnel, holds monthly meetings with all chiefs of service.

Section 6.03 Governance Council

The Governance Council will review, monitor, and control necessary actions required to assure quality of care. The council will assure that all proper actions are taken to comply with the standards required by the Joint Commission.

The council will also review, monitor, and control actions relative to the assessment of the quality of care and findings and recommendations of external surveys performed by the Department of Veterans Affairs and other organizations.

ARTICLE VII. APPOINTMENT AND ONGOING CREDENTIALING

Note: Credentialing and Privileging will be conducted in accordance with VHA Handbook 1100.19 Credentialing and Privileging

Section 7.01 General Provisions

1. All members of the Medical Staff, as defined in Article III, Section 3.01 para. 2 and all non-Medical Staff practitioners who hold clinical privileges will be subjected to full credentials review at the time of initial appointment, appraisal or reappraisal for granting of clinical privileges, and after a break in service of more than 15 workdays as outlined in this Article. Credentials that are subject to change during leaves of absence will be subjected to review at the time the individual returns to duty.
2. Appointments to the Medical Staff occur in conjunction with VA employment or utilization under a VA contract or sharing agreement. The authority for these actions are based upon:
 - A. Provisions of 38 U.S.C. in accordance with VHA Human Resources 5000 series. (add Title 5 references if applicable to the individual Medical Staff composition) and applicable Agreement(s) of Affiliation in force at the time of appointment.
 - B. Federal Law authorizing VA to contract for health care services.
3. Probationary Period. Initial and certain other appointments made under Title 38 U.S.C. 7401(1), 7401(3), 5 U.S.C. 3301, are probationary; others may apply. During the probationary period; professional competence, performance, and conduct will be closely evaluated under applicable VA policies and procedures. If, during this period, the employee

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

4. Regularly appointed United States citizen staff members will be granted an initial one or two-year probationary appointment depending upon their professional discipline with career appointment to follow, subject to annual review. Removal from the staff may be only for disciplinary reasons, in accordance with VA Regulations. This tenured status is not applicable to any type of appointment other than full-time permanent.
5. For licensed non-citizen individuals with permanent (immigrant) visas, appointments will be three-year, temporary, renewable once, and subject to annual review VHA Human Resources 5000 series.
6. All service chiefs are appointed by VA Headquarters for an indefinite term.
7. Consultants and attendings are proposed by the respective chief of service to the Deans Committee for concurrence and nomination to the Chief of Staff and Center Director for approval and appointment.
8. Appointment to the Medical Staff may be based on the ability of the medical center to provide adequate facilities and supportive services for the applicant and his/her patients.
9. All members have delineated clinical privileges, which allow them to provide patient care services independently within the scope of their clinical privileges.

Section 7.02 Application Procedures

- 1 Complete Application. Applicants for appointment to the Medical Staff must submit a complete application. To be complete, applications for appointment must be submitted by the applicant on forms prescribed and approved, and include authorization for release of information pertinent to the applicant and information regarding:
 - A. Items specified in Article III, Section 3.01, Qualifications for Medical Staff Membership:
 - i. Active, current, full, and unrestricted license
 - ii. Education
 - (a) Curriculum vitae - delineate all professional education and work experience
 - (b) Relevant training and/or experience
 - (c) Current competence
 - iii. Physical examination and mental health status
 - iv. Response time from residence (for on-call responsibility)
 - v. English language proficiency
 - vi. Contract Medical Staff Members must possess professional liability insurance.

- B. U.S. Citizenship. Applicant must be a citizen of the United States. When it is not possible to recruit qualified citizens, practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment, with proof of current VISA status and documentation of employment authorization (from Immigration and Naturalization Service), pursuant to qualifications as outlined in 38 U.S.C. 7405 and VHA Human Resources 5000 series.
- C. References. Names and addresses of a minimum of three (3) 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. At least one of the references must be from the current or most recent employer(s) or institution(s) where clinical privileges are/were held. In the case of individuals completing residencies, one reference must come from the residency program director.
- D. Previous Employment. A list of all health care institutions where the practitioner is/has been appointed, utilized, or employed, including:
 - i. Name of health care institution or practice,
 - ii. Term of appointment or employment, and
 - iii. Privileges held and any disciplinary actions taken against the privileges, including suspension, revocation, limitations, or voluntary surrender.
- E. DEA (Drug Enforcement Administration) registration
 - i. Of those who have, or have had, DEA registration.
 - ii. Previously successful or currently pending challenges to DEA registration or the voluntary relinquishment of such registration.
- F. Challenges to license, including 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. Status of any claims made against the practitioner in the practice of any health occupation, as a minimum, final judgments or settlements of professional liability actions must be disclosed.
- H. 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. Previous or pending challenges against the practitioner by any hospital, licensing board, law enforcement agency, professional group, or society.
- J. 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.

K. Approval from Headquarters, if applicable.

2. Documents required in addition to those listed above include:

A. Picture ID – (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). NOTE: The approved picture ID must be viewed again on the day they first report to duty.

B. Documentation of current or most recent clinical privileges held, if available.

C. Verification of status of licenses for all states in which the applicant has ever held a license.

D. For foreign medical graduates, evidence and verification of the Educational Commission for Foreign Medical Graduates (ECFMG) certificate.

E. Evidence and verification of board certification, if claimed.

F. Verification of education credentials used to qualify for appointment (and privileges) including all postgraduate training.

G. Reports of queries to the National Practitioner Data Bank (NPDB), for all members of the Medical Staff and those practitioners with clinical privileges.

H. Confirmation of health status.

I. Results of review of the OIG Sanction List (also known as HSS Cautionary List)

J. A signed statement that the applicant will abide by the Medical Staff Bylaws and Rules, medical center policies, and VA regulations that apply to his activities and to provide continuous care for his patients.

3. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant 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 may serve as a basis for denial of employment consideration.

Section 7.03 Process and Terms of Appointment

1. The chief of the service to which the applicant is to be assigned is responsible for recommending appointment to the Medical Staff based on:

- A. Evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.
 - B. Recommendations by the UMC departmental Chairperson will be considered, where applicable.
2. The CEB recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.
 3. A Professional Standards Board (PSB) will be held within 30 days of receipt of all verified information. The PSB is a subcommittee of the Clinical Executive Board (CEB). The Board is composed of a minimum of three members, one of whom is the Chief of Staff who serves as Chair. The PSB will review the applicant's credentials and will recommend approval/disapproval of Medical Staff membership.
 4. Application for Medical Staff membership will normally be acted on by the CEB during the first board meeting following receipt of recommendations of the PSB. Based upon CEB recommendations, the Center Director will appoint or reject the applicant. Due process of rejected applicants is provided in accordance with Federal Regulations as outlined in VA Directive 5977 Equal Employment Opportunity Discrimination Complaints Process.
 5. Appointments to the Medical Staff should be acted upon by the Center Director within 45 days of receipt of a complete application including all required verifications, references and recommendations from the appropriate service chief, PSB, and CEB.
 6. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or non-appointment within 10 days of an action by the Center Director. In the case that appointment is not approved, reasons will be provided.
 7. Temporary Appointments and Privileges in Emergency Situations:
 - A. The recommendation for temporary privileges will be made by the COS and approved by the Center Director. Temporary privileges should not exceed 60 calendar days.
 - B. Prior to appointment and privileging, verification of the following must be made:
 - Current Licensure
 - Relevant training or experience
 - Current competence
 - Ability to perform the privileges requested
 - Other criteria required by the organized medical staff bylaws
 - A query and evaluation of the NPDB information
 - A complete application
 - No current or previously successful challenge to licensure or registration

- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

8. Emergency Privileges During Disasters:

A. During disaster(s) in which the emergency management plan has been activated and the hospital is unable to meet immediate patient needs, privileges may be granted by the Chief of Staff and/or the Center Director or their designee(s). Utilizing direct observations and record reviews with standardized triggers, the professional performance of volunteer providers granted disaster privileges will be monitored and overseen by the medical staff. Individuals granted emergency privileges during times of disaster will be identified through the hospital identification program. Privileges will be granted on a case-by-case basis after presentation valid government-issued photo identification, issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current picture hospital identification card that clearly identifies professional designation.
- A current license to practice.
- Primary source verification of the license begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
NOTE: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organization or groups..
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- Identification by current hospital or medical staff members(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

B. The Chief of Staff and/or the Center Director or their designee(s) will decide within 72 hours if the disaster privileges initially granted a practitioner will continue. The decision will be based on information obtained regarding the profession practice of the volunteer.

C. Disaster privileges will not exceed 10 calendar days or the length of the disaster, whichever is shorter. At the end of this period, the practitioner will be converted to temporary privileges or relieved.

9. Expedited Appointment: The Credentialing process for an expedited appointment cannot begin until the licensed independent provider completes the credentials package including but not limited to a complete application, therefore the provider must submit this information through VetPro and documentation of credentials must also be retained in VetPro. Note: VetPro is VHAs electronic credentialing system and must be used for credentialing all providers who are granted clinical privileges or credentialed for other reasons.

To expedite the appointment of a provider, the Credentialing and Privileging Section must verify all of the education and training, one active current unrestricted license verified by primary source., current comparable privileges held in another institution, confirm two peer references, confirm the declaration of health, query *NPDB-HIPDB*, query *FSMB*, and have the executive of the clinical service, or care line approval.

- A. An applicant is ineligible for the expedited process if at the time of appointment any of the following has occurred:
- i. The applicant submits an incomplete application;
 - ii. The Clinical Executive Board makes a final recommendation that is adverse or with limitation
 - iii. There is a current challenge or a previously successful challenge to licensure or registration;
 - iv. The applicant has received an involuntary termination of medical staff membership at another organization;
 - v. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;
 - vi. There has been a final judgment adverse to the applicant in a professional liability action.
10. If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted, and there is no history of malpractice payment, the delegated Professional Standard Board may recommend appointment to the medical staff. This recommendation, by the Professional Standard Board, will be acted upon by the Medical Center Director. Full credentialing must be completed within 30 workdays and presented to the Clinical Executive Board for ratification. This is a one-time appointment process for initial appointment to the medical staff and may not exceed 45 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 45 calendar days of the Expedited Appointment or the medical staff appointment is

automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director even though ratification of the appointment is accomplished within 45 calendar days (the effective date does not change).

Section 7.04 Credentials Evaluation and Maintenance

1. The service chief has the responsibility to ensure each Medical Staff member assigned to his service practices within the scope of privileges granted. Clinical privileges will be reviewed and approved biennially by the service chief, CEB, Chief of Staff, and Center Director.
2. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible or from a credentials verification organization (CVO) the following information:
 - A. The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration.
 - B. The applicant's relevant training.
 - C. The applicant's current competence
3. When it is not possible to obtain information from the primary source, reliable secondary Sources may be used. Designated secondary sources include but are not limited to the following:
 - A. The American Medical Association (AMA) Physician Master file for verification of a physician's United States and Puerto Rican medical school graduation and residency completion.
 - B. The American board of Medical Specialties (ABMS) for verification of a physician's board certification.
 - C. The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school.
 - D. The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA Bureau of Professional Education; postdoctoral education approved by the AOA Council on Postdoctoral Training; and Osteopathic Specialty Board Certification.
 - E. The Federation of State Medical Boards (FSMB) for all actions against a physician's medical license.
 - F. The American Academy of Physician Assistants (AAPA) Profile for physician assistant education and National Certification Commission (NCCPA) certification.
 - G. The American Nurses Credentialing Center (ANCC) for verification of a nurse practitioner's certification.

4. Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff performance improvement indicators) 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. This process may include an assessment for proficiency in the areas of general competencies defined in Article VII.
5. Any new credentials claimed by the practitioner will be verified per Article VIII, Section 8.02, Paragraph 2. Efforts will be made to verify, with primary sources, all credentials claimed.
6. A Credentialing and Privileging Folder will be established and maintained for each practitioner requesting privileges. These folders will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging. At any time that a folder is found to lack required documentation for any reason, effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the folder stating the reason. The entry will also detail the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort.
7. Ongoing Professional Practice Evaluation. Each practitioner will have an ongoing assessment review of his activities, conducted by clinical supervisor; which includes information relative to the individual's professional performance, judgment, clinical skills, and, when appropriate, technical skills. Assessment is ongoing with annual review with providers. Other review parameters should include the individual's maintenance of timely, accurate, and complete Medical Staff records; involvement in Performance Improvement activities; attendance at required staff and departmental meetings; service or medical center committees; consideration of practitioner's health status; and patterns of care as demonstrated by reviews and evaluations conducted by committees such as, Medical Records, Utilization Review, etc. A review of the practitioner's participation in continuing education will also be included. Findings will be documented by his clinical supervisor on VA Proficiency Form 10-2623 or the appropriate form for the professional discipline. Additionally, specific provider profile data will be aggregated and submitted to appropriate service chiefs quarterly. This form will be shown to the practitioner and initialed or signed by him to document his review of it. The completed form will be forwarded to the Chief of Staff for his review and endorsement. Unsatisfactory ratings will be processed in accordance with VA Regulations. Any staff member not satisfied with his review will be afforded the opportunity to reply and appear before an appropriate board.
8. Focused professional practice evaluation. Focused professional practice evaluation is a process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance. Time periods for evaluation will vary depending upon the privilege requested and/or the

circumstances that result in questionable patient care.

The organized medical staff does the following:

- A. Evaluates practitioners without current performance documentation at the organization.
- B. Evaluates practitioners in response to concerns regarding the provision of safe, high quality patient care.
- C. Develops criteria for extending the evaluation period.
- D. Communicates to the appropriate parties the evaluation results and recommendations based on results.
- E. Implements changes to improve performance

Ongoing and focused practice evaluations are protected documents under CPM A-11Q-39 "Confidentiality of Quality Management Documents."

ARTICLE VIII. CLINICAL PRIVILESGES

Note: Credentialing and Privileging will be conducted in accordance with VHA Handbook 1100.19 Credentialing and Privileging.

Section 8.01 General Provisions

- 1 Medical center specific privileges are granted for a period of two years.
- 2 The medical center shall confer on the appointee only such clinical privileges/enhancement/modifications as specified. Privileges granted to an applicant must be hospital-specific, have necessary resources, equipment, space, and personnel available to support the requested privilege, based on the procedures and types of services that are provided within this medical center and deemed needed by the Chief of Staff and Center Director.
- 3 Patient care activities of personnel in the following categories provide patient care services independently and require that their authority for specified services be processed through the Medical Staff. Accordingly, the CEB will approve clinical privileges requested for individuals in these categories:
 - Physician
 - Dentist
 - Certified Registered Nurse Anesthetist
 - Psychologist
 - Podiatrist
 - Nurse Practitioner
4. Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link. The medical staff shall determine which clinical services are appropriately delivered through this medium. This determination will be discussed and documented at the CEB. Others professional disciplines may practice

telemedicine through a scope of practice. If a member of the medical staff proposes, by telemedicine, to prescribe, render a diagnosis, or otherwise provide clinical treatment to a patient, he/she will be credentialed and privileged through the medical staff mechanism set forth in these Bylaws.

5. Ongoing assessment and biennial reappraisal of each Medical Staff member and any other practitioner who holds clinical privileges is required. Reappraisal includes a review of performance, current competency, an evaluation of the individual's physical and mental status, and assessment of the individual's current privileges. It also requires verification of satisfactory completion of 16 hours of documented AMA Category I or II continuing education or the professional equivalent. Reappraisal is initiated by the practitioner's service chief at the time of a request by the practitioner for new and renewed clinical privileges.

Section 8.02 Process and Requirements for Requesting Clinical Privileges

1. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant 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 may serve as a basis for denial of employment consideration.
2. Every initial application for staff appointment must contain a request for privileges from the practitioner with the recommendations of the chief of the service for which he applied. The request for initial clinical privileges must be made in writing and include privileges requested within well-defined limits in a form approved by the CEB and accompany a complete application for privileges which will include:
 - A. Complete appointment information as outlined in Section 7.02 of Article VII.
 - B. Application for clinical privileges as outlined in Section 8.02 para. 2 of this Article.
3. The practitioner applying for clinical privileges subsequent to those granted initially will provide the following information:
 - A. An application for clinical privileges as outlined in Section 8.02 of this Article. (Since practice, techniques, and facility missions' change over time, it is expected that modifications, additions, or deletions to existing clinical privileges will occur. Practitioners are encouraged to consider carefully and discuss appropriateness of specific privileges with the appropriate service chief prior to formal submission of the request.)
 - B. Supporting documentation of professional training and/or experience not previously submitted.
 - C. Physical and mental health status as it relates to practitioner's ability to function within privileges requested including such reasonable evidence of health status that may be

required by the CEB.

- D. Documentation of continuing medical education related to the area and scope of clinical privileges will be submitted.
 - E. Status of all licenses, certifications held.
 - F. Any sanction(s), final judgments, or settlements by a hospital, state licensing agency, or any other professional health care organization; voluntary or involuntary relinquishment of licensure or registration; any malpractice claims, suits or settlements; 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 copies of the privileges held.
4. Bylaws Receipt and Pledge. Prior to the granting of clinical privileges, Medical Staff members or applicants will pledge, in writing, to provide for continuous care of their patients and will receive a copy of the Bylaws and Rules and agree to abide by the professional obligations therein.
5. Verification.
- A. Verification of credentials prior to granting of initial privileges will be accomplished as described in Article VII, Section 7.03, "Process and Terms of Appointment."
 - B. Before granting subsequent clinical privileges, the Chief of Staff will assure that the following information is on file and verified with primary sources, as applicable:
 - i. Current and former licenses in all states.
 - ii. Current and former DEA license and/or registration.
 - iii. National Practitioner Data Bank query.
 - iv. Physical and mental health status information from applicant.
 - v. Physical and mental health status confirmation and professional competence information from peers, service chief.
 - vi. Continuing education to meet any local requirements for privileges requested.
 - vii. Board certification(s).
 - viii. Quality of care information.

Section 8.03 Process and Requirement for Requesting Renewal of Clinical Privileges

- 1. Renewal of clinical privileges will be conducted biennially and is based on ongoing professional practice evaluation of the individual as defined in Section 3 of this article. Renewal of Clinical privileges will include the following:
 - A. Evaluation of practitioner specific information as outlined in center policy CPM F-11Q-48 Medical Staff Professional Practice Evaluations & Performance Profiles, core competencies, and peer recommendation(s), including service chief recommendation(s).

- B. Verification of current medical licensure and Drug Enforcement Administration (DEA) registration, if applicable; information on health status, professional performance, judgment, and clinical/technical skills, as indicated in part by the results of performance improvement activities; previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration; and voluntary or involuntary termination of Medical Staff membership; or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and other reasonable indicators of continuing qualifications.
- C. The practitioner shall submit any reasonable evidence of current health status that may be required by the CEB.
- D. Actions on renewals or revisions of clinical privileges will be reviewed by PSB within 30 days and be acted on in the first CEB meeting following receipt by the Chief of Staff of a completed request for renewal/revision. The candidate and service chief will be notified of the action within 10 days of signature by the Center Director.
- E. Reduction or revocation of clinical privileges will be processed in accordance with VA Regulations and Medical Center Policy (CPM). Material, which is gathered as part of the performance improvement program, may not be disclosed in the course of any action to reduce or revoke privileges. 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.

Section 8.04 Processing an Increase or Modification of Privileges

1. Other licensed practitioners who are presently permitted by law and the medical center to provide patient care services independently, will be granted clinical privileges based on their assignments and responsibilities.
2. A practitioner's request for modification/enhancement of existing clinical privileges will be made by practitioner submission of a formal request for the desired change(s) with full documentation to support the change.
3. Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline, or position.
4. Practitioners with clinical privileges are assigned to and have clinical privileges in one clinical department/service, but may be granted clinical privileges in other clinical departments/services. Privileges requested from a department/service to which the practitioner is not assigned will be reviewed and recommended according to the established mechanisms for that department/service.
5. Exercise of clinical privileges within any service is subject to the rules of that service and

to the authority of that service chief.

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

Section 8.05 Recommendation and Approval for Renewal and Revision of Clinical Privileges

1. Peer recommendations will be obtained from individuals who can provide authoritative information regarding training/experience, professional competence and conduct, and health status.
2. The service chief to whose service the applicant for clinical privileges is assigned is responsible for assessing all information and recommending approval of clinical privileges.
 - A. Recommendation for initial privileges will be based on the determination that applicant meets criteria for appointment and clinical privileges for the service including requirements regarding education, training, experience, references, and health status.
 - B. Recommendation for clinical privileges subsequent to those granted initially will be based on, at least, 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 operative and invasive procedures review, medical record review, blood usage review, and risk management activities.)
3. The CEB recommends granting clinical privileges based on each applicant's successfully meeting the requirements for clinical privileges as specified in these Bylaws.
4. Clinical privileges are acted upon by the Center Director within 45 days of receipt of a complete application for clinical privileges that includes all requirements set forth in Article VII, Section 7.02.
5. Originals of approved clinical privileges documents are placed in the individual practitioner credentialing and privileging folders. A list of procedures performed and staff authorized to perform them will be maintained in the emergency room and intensive care units.

Section 8.06 Exceptions

Emergency Care. Any Medical Staff member is permitted to provide emergency care, within the scope of his license, to any individual whose life, sight, or limb is in immediate danger and delay would place the patient at risk. Therefore, staff, do not have to be granted privileges to perform those procedures, which are only performed under emergency circumstances. Emergency care may also be provided by properly supervised members of house staff.

ARTICLE IX. INVESTIGATION AND ACTION

Section 9.01 Denial of Medical Staff Appointment

1. When review of credentials and recommendations contained in a complete application result in denial of appointment, the applicant will be notified by the chairperson of the PSB in a letter over the signature of the Chief of Staff. The notification will briefly state the basis for the action.
2. The Chief of Staff will appoint a board of investigation to conduct a fair hearing within 30 days when requested to do so by individuals who have had an initial request for appointment or privileges denied.

ARTICLE X. FAIR HEARING AND APPELLATE REVIEW

Section 10.01 Actions Against Clinical Privileges

1. When recommendations regarding clinical privileges are adverse to the applicant, including but not limited to reduction and revocation, procedures in CPM K-11P-60 "Credentialing, Privileging of Independent Practitioners" and CPM F-11P-34 "Reduction or Revocation of Clinical Privileges of Medical or Professional Staff" will be followed.
2. The Center Director may, on the recommendation of the Chief of Staff, summarily suspend Medical Staff Membership or suspend clinical privileges on a temporary basis, pending the outcome of formal action. This action is taken when the medical staff member does not possess a valid medical license or when there is sufficient concern regarding patient safety or specific practice patterns consistent with requirements in VHA policy on credentialing and privileging of physicians and dentists to justify this immediate action.
3. Disciplinary and performance based privilege changes (including suspension of an individual's Medical Staff membership and/or clinical privileges, grievances, appeals, and hearings) are undertaken after due process procedures consistent with those outlined in VHA policy on credentialing and privileging of physicians and dentists. In such circumstances, the provider will be afforded the opportunity to review and edit for accuracy any transcript of their own testimony taken in such action. The affected provider will be notified of proposed changes in writing by hand-delivery or registered mail.

Section 10.02 Reporting Adverse Actions

1. Disclosure of information to State licensing boards regarding practitioners separated from VA service will be completed in accordance with VA policy.
2. Disclosure of information to the National Practitioner Data Bank (NPDB) through State licensing boards regarding adverse action against clinical privileges of more than 30 days will follow provisions of the VHA policy on NPDB Reporting.

Section 10.03 Reporting Malpractice Payments

Disclosure of information regarding malpractice payments determined by peer review to be related to professional incompetence or professional misconduct on the part of a practitioner will follow provisions of the VHA policy on National Practitioner Data Bank Reports.

Section 10.04 Termination of Appointment

Clinical Executive Board (CEB) may recommend medical staff membership termination to the governing body. Termination of Medical Staff appointments will be accomplished in conjunction with, and follow procedures for; terminating appointments of practitioners set forth in VHA Human Resources 5000 series.

ARTICLE XI. RULES AND REGULATIONS

1. The Medical Staff shall adopt such rules (not in conflict with the requirements of Federal Law) as may be necessary to implement more specifically the general principles found within these Bylaws and guidelines of the Governing Body, subject to approval of the Center Director. Such rules shall be a part of these Bylaws. They may be amended at any regular or special meeting, without previous notice, by a two-thirds' vote of the members present or by an approved electronic voting mechanism following format presentation at a meeting. Fifty percent of the active staff constitutes a quorum. Such changes shall become effective when approved by the Center Director.
2. Published and numbered Center Policy Memoranda are an extension of the Medical Staff Rules.
3. In cases of a documented need for an urgent amendment to the rules necessary to comply with law or regulation, the Clinical Executive Board may adopt the provisional amendment to the rules that is deemed necessary for legal or regulatory compliance. After adoption, this provisional amendment to the rules will be communicated back to the organized Medical Staff for review within 3 days. The amendment will stand if approved by two-thirds of a quorum of the active Medical Staff present in a Medical Staff meeting or by an approved electronic voting mechanism following formal presentation at a meeting. If the active Medical Staff does not approve the amendment, the amendment will not stand and will be given over to the conflict resolution process if needed. The conflict resolution process will be initiated using VA Directive 5978/1)

ARTICLE XII - AMENDMENTS

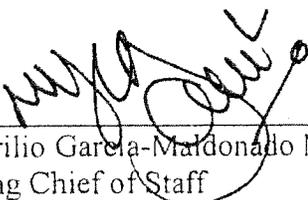
1. These Bylaws and all attachments shall be reviewed, revised, and/or amended as necessary to reflect current practices with respect to Medical Staff organization and functions; and shall be dated to indicate the date of last review. Neither the medical staff nor the governing body may unilaterally amend the medical staff by-laws or rules and regulations.
2. The responsibility for review or revision lies within the office of the Chief of Staff.

- a. 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 will be notified of the date proposed changes will be considered.
 - b. Proposed amendments to the Bylaws and Rules and attendant policies may be submitted in writing to the Chief of Staff by any service chief or member of the Medical Staff.
3. These Bylaws shall be amended after presentation to members of the Medical Staff. For adoption, any amendment shall require a two-thirds (2/3) vote of those active staff members present or by approved electronic voting.
 4. All changes to the Bylaws require action by both the Medical Staff and Center Director. Neither may amend unilaterally.
 5. Changes are effective when approved by the Center Director.

ARTICLE XIII - ADOPTION

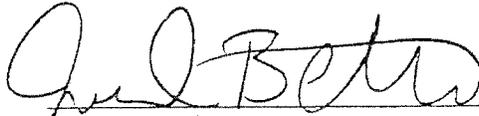
These Bylaws, with the supporting Rules, shall be adopted upon recommendation of the Medical Staff at any regular or special meeting of the active Medical Staff at which a quorum is present or by an approved electronic voting mechanism following formal presentation at a meeting; shall replace any previous Bylaws and Rules; and shall become effective when approved by the Center Director. The Center Director shall inform the medical staff, in writing within 30 days, of his decision not to approve any changes to the Bylaws or Rules of the Medical Staff duly passed by the Medical Staff at a regular or special meeting.

Adopted by the Medical Staff on Dated: 9/28/2012



Maurilio Garcia-Maldonado M.D.
Acting Chief of Staff

Adopted by the Center Director on Dated: 9/29/12



Joe D. Battle
Center Director

MEDICAL STAFF RULES

1. GENERAL

- B. PURPOSE.** These Rules relate to the roles and/or responsibilities of members of the Medical Staff which includes individuals with clinical privileges such as psychologists, nurse anesthetists, nurse practitioners, and podiatrists. The Rules apply to the care of inpatients, emergency care patients, and ambulatory care patients as a whole or to specific groups as designated.
- C. SERVICE RULES.** Rules of medical center services will not conflict with these Bylaws and Rules, policies of the Medical Staff, requirements of the Governing Body, or the rules of other services.
- D. MEDICAL CENTER POLICY.** Published and numbered Center Policy Memoranda (CPM) is considered an extension of these Rules and Bylaws. As such, these memoranda shall also guide the Medical Staff in the accomplishment of their duties. They are available to all staff directly, through service chiefs and from the office of the Chief of Staff. They are available to prospective staff for review upon request.
- E. GENDER.** Any reference to gender in these Rules and Bylaws, "he" or "she", shall be applicable to both sexes.

2. PATIENTS' RIGHTS

- A. RIGHTS and RESPONSIBILITIES.** This medical center supports the rights of each patient and addresses those rights prominently in published policies and procedures for both staff and patients; they include:
- i) **Treatment and Care.** A patient shall be provided equitable and humane treatment, integrated with considerate and respectful care, at all times. He is entitled to a reasonable response to his requests and need for service within the capacity, mission, laws, and regulations, which govern the medical center.
 - ii) **Privacy and Confidentiality.** Every individual who enters this hospital for care retains certain rights for privacy; not only the privacy of his body, but the privacy of disclosure. Therefore, all verbal or written disclosures of facts regarding a patient, other than to the family and authorized VA and congressional inquiries, will be cleared through the Health Information Management Section in Medical Administration Service.
 - iii) **Communication.** The patient has the right to communicate and collaborate with those responsible for his care and to receive from them adequate information concerning the nature and extent of his clinical problem, the planned course of treatment, and the prognosis with consideration to advance directives made by the patient.

- iv) **Information and Education.** The patient has the right to know the identity of the physician who is primarily responsible for his care and to be informed as to the nature and purpose of any technical procedures that are to be performed on him, as well as to know by whom such procedures are to be carried out. He shall expect adequate instruction in self-care for the interim between visits to the hospital or to the physician. He has the right to access information necessary to make healthcare decisions that reflect his wishes and to information regarding any human experimentation or research/education projects affecting patient care.
- v) **Representation.** Every patient has the right to participate in or to be represented in the consideration of ethical decisions regarding care or in resolving complaints. A patient may formulate advance directives and appoint a surrogate to make health care decisions in his behalf. A legally authorized person may exercise the patient's rights if the patient is judged incompetent in accordance with law, or is found by the physician to be medically incapable of understanding treatment, or is unable to communicate his wishes.
- vi) **Refusal.** The patient has the right to refuse treatment to the extent permitted by law, to include foregoing or withdrawing life sustaining treatment including resuscitation, and to be informed of the medical consequences of his action.
- vii) **Documentation.** Patient education and informed consent are considered an essential part of the patient's clinical record and should be clearly documented on the patient's chart.

B. PATIENT SELF-DETERMINATION. This Medical Staff and medical center recognizes the patient's right to self-determination in health care decisions and the role of the medical center to assist him in that process. Patients have rights as outlined in State and Federal statutes to execute advance directives. It is the physician's role to provide the necessary medical facts and recommendations to the patient or surrogate decision-maker for his subjective decision concerning treatment based upon their understanding of the facts presented. These concepts are detailed in CPM F-125-20 "Informed Consent for Clinical Treatments and Procedures" and include: informed consent, advance directives, do-not-resuscitate instructions, organ or body donation, surgical, and other invasive procedures performed without blood transfusions or blood products.

3. RESPONSIBILITY FOR CARE

A. CONDUCT of CARE.

- i) The care of each patient shall be the responsibility of a member of the Medical Staff with appropriate privileges. Such staff member shall be responsible for medical or dental care and treatment and for prompt completion and accuracy of the medical record. He shall be responsible for any special instructions regarding the patient and for transmitting, through established medical administrative procedures, reports on patient condition to the referring practitioner and family of the patient. Although the

day-to-day treatment of the patient may be delegated to the supervised house staff, the responsibility for patient care rests with the member of the Medical Staff. Whenever these responsibilities are transferred to another staff physician or service, an order covering the transfer shall be entered in the medical record.

- ii) The same level of care (inpatient/outpatient and medical, surgical, dental, anesthesia, and other) shall be applied with the same standard and maintained at a comparable level throughout the medical center.
- iii) The attending physician (inpatient) or primary care provider (outpatient) will be responsible for coordination of care, treatment, and services among the practitioners involved in a patient's care, treatment, and services.

B. DENTAL SERVICES.

- i) A physician member of the Medical Staff must be responsible for the care of any medical problem that may be present or that may arise during the hospitalization of a dental patient.
- ii) Dental surgical privileges must be specifically defined in the same manner as other surgical privileges and may be exercised only under the overall supervision of the Chief, Surgical Service.

C. OTHER LICENSED PRACTITIONERS. Licensed healthcare professionals, other than members of the organized medical staff, whose patient care activities require delineation of clinical privileges may render services to patients under the following conditions:

- i) Each individual in this category will present his request for clinical privileges and qualifications for review by the appropriate service. If approved, the governing body may grant such individual privileges.
- ii) They may not admit patients independently.
- iii) Services will be performed only at the request of a member of the Medical Staff who shall be responsible for the patient and his medical records.
- iv) Activities of these individuals will be limited to those defined in their scope of practice approved by their collaborative/consultant physician and approved by the medical staff.

D. ADMISSIONS.

- i) Individuals granted the privilege to admit to inpatient services must be physician members of the Medical Staff.
- ii) Except in an emergency, no patient will be admitted to the hospital until after a

provisional diagnosis has been stated on the medical record. The hospital shall admit legally eligible patients suffering from any type of disease or injury, which in the opinion of the admitting physician, can be treated at this hospital or should be admitted for humanitarian reasons until such time as the patient may be transferred to a suitable hospital equipped to care for the disease or injury. The Medical Staff members or house officers will promptly examine and make the proper disposition of all applicants eligible for care. Any patient may be admitted for emergency care.

- iii) Final authority for admission and assignment to a service rests with the admitting physician and is not subject to rescission by the service receiving the patient. When an admission to a specialty service is considered to be necessary by the admitting physician, the service should be contacted for consultation. If this consultation is not provided within one hour, the patient may be admitted to the service in question by the admitting physician.
- iv) Nursing Service will be responsible for promptly notifying the responsible receiving physician as soon as a new patient has arrived on the ward.
- v) All patients shall be attended by a physician member of the Medical Staff.
- vi) H&P (History and Physical) Examination: An H&P examination and tentative diagnosis shall be accomplished and documented by a physician within 24 hours of admission of the patient. The H&P and required updates will be performed by a practitioner who has been granted privileges to do so. Individuals who are not licensed independent practitioners may perform part or all of a patient's H&P under the supervision of or through appropriate delegation by a specific qualified doctor of medicine or osteopathy member of the medical staff who is then accountable for the patient's medical H&P as signified by co-signature. If dictated for transcription a brief electronic admission note containing pertinent findings (i.e., enough information for clinicians to manage the patient and guide the plan of care), will be on the chart within 24 hours. Interval notes may be used if a patient is readmitted within 30 days to the same service. Medical Staff admitting patients shall be responsible for prompt completion and accuracy of medical records. Dentists will provide appropriate dental elements of the H&P examination when the patient is admitted for dental care. For non-inpatient procedures, the H&P must be relevant to the specific procedure and must always include a cardiopulmonary exam. This would be in addition to any evaluation that anesthesia would perform.

vii) Tests

- (1) On admission to the hospital, each patient shall have appropriate laboratory and x-ray examinations. However, there will be no standing or routine orders.
- (2) HIV testing will not be conducted without the prior, informed, separate, written consent of the patient.

E. TRANSFERS.

i) General and Internal

- (a) Patients shall not be transferred from one service to another, or out of an ICU or recovery room, without a written order in the chart by the practitioner responsible for his care.
- (b) Transfers from one service to another will be accomplished by mutual agreement of the services involved.
- (c) All pertinent medical information will accompany the patient. Orders will automatically be canceled on moving from one service to another.
- (d) Nursing Service will be responsible for promptly notifying the responsible receiving physician as soon as a new patient has arrived on the ward.

F. External.

- i) No patient who meets eligibility criteria or is in need of emergency or humanitarian care shall be arbitrarily transferred out when this medical center has the means to provide adequate care.
- ii) Each potential transfer to the medical center shall be considered using the criteria of:
 - (a) the medical center to provide appropriate care and (b) the patient's stability to endure a move without detrimental effect.

F. CONSULTATIONS.

- i) **Requirement.** Except in an emergency, consultation with another qualified physician is required when in the judgment of the patient's attending staff member:
 - (a) The patient is not a good risk for operation or treatment.
 - (b) The diagnosis is obscure.
 - (c) There is doubt as to the best therapeutic measures to be recommended and utilized.
 - (d) Psychiatric consultations and treatment should be requested and offered to all patients who have attempted suicide or have taken a chemical overdose. That such services were at least ordered must be documented in the patient's medical record.
- ii) **Consultant.** A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical

Staff on the basis of the individual's training, experience, and competency. Resident staff may act as consultants when approved by the service chief and consistent with center policy on resident supervision.

iii) Essentials. A satisfactory consultation includes an examination of the patient, his records, and appropriate documentation. When operative procedures are involved, the consultation, except in an emergency, shall be reported prior to the operation.

iv) Responsibility.

(a) The service chiefs will assure that members of their staff provide timely consultation, as needed.

(b) The attending physician in conjunction with other members of the health care team will have the final decision as to whether treatment or procedures recommended by the consultant are implemented. There should be documented agreement between the primary treating service and a consultant before a diagnostic or therapeutic procedure is performed.

(c) If agreed, consultants may write orders on patients of another physician or service.

(d) Good medical judgment shall always be exercised in initiation of consultation requests in order to avoid overburdening the consulting section, department, or individual. Consultation should be requested for valid medical or educational reasons.

(e) Medical ethics shall be followed by consultants.

v) Initiating Requests. Consultation should be initiated by the attending Medical Staff member or by the house staff. The consultation should be in writing, on the appropriate form, and addressed to a specific service or person. Consultation requests should be written clearly, setting forth the problem and the information requested.

vi) Response.

(a) The responsibility of determining policy regarding response to consultation requests, usually within 24 hours for inpatients and 30 days for outpatients, rests with the chief of the clinical service and/or subspecialty section from which consultative support has been requested. The guiding philosophy shall be to provide consultation with a high level of professional competency, efficiency, and promptness, both for service to the patient and for educational purposes. Whenever possible, the clinical staff practitioner will answer the consultation either individually or jointly with the resident. It is recognized that this is difficult within small clinical services and sections. In some instances, advanced, competent residents may respond to consultation requests. The resident

responding should be licensed to practice. The person actually examining and writing the consultation advice should affix his signature to the consultation, thus fixing the medical and legal responsibility.

- (b) In every instance where the clinician originating the request for consultation specifically requests a particular staff physician or dentist, his request should be honored by the consulting service or section.

vii) Nursing Service. If a nurse has any reason to doubt or question the care provided to any patient and feels that appropriate consultation is needed and has not been obtained, he shall direct such questions to the attending staff member. If, after this, he still feels that the questions have not been resolved, he shall call this to the attention of his supervisor, who, in turn, may refer the matter to the Chief, Nursing Service. The Chief, Nursing Service shall bring the matter to the attention of the appropriate service chief.

G. DISCHARGE.

- i) Patients shall be discharged only on written order of an authorized practitioner. Insofar as possible, discharge orders will be written 24 hours in advance of the contemplated departure of the patient. No discharge will be affected without compliance with provisions of Section 6, Medical Records.
- ii) Against Medical Advice (AMA). Should a patient leave the hospital against the advice of the attending staff member or without proper discharge, notation of this incident shall be made in the patient's medical record. An AMA discharge shall be recorded in the patients' record.
- iii) Missing patient. When a patient has been declared a "missing patient," policies and procedures in CPM B-136-03, "Management of Wandering and Missing Patients (Inpatients and Outpatients)", will be followed.

H. AUTOPSY

- i) In the interest of improving patient care and professional knowledge, every member of the professional staff is expected to actively participate in securing permission for autopsies in all deaths. Special effort will be made to secure an autopsy when death is unexpected or the cause is in question. The following criteria will be used:
 - Sudden and unexpected deaths during hospitalization.
 - Death during or within 24 hours of an invasive procedure.
 - Death of patients on whom a diagnosis was not fully established.
 - Death from nosocomial infection not resolved.
 - Death during trial of new or experimental drugs or therapy.
 - Death in which abuse is suspected.
 - Death under anesthesia.

- Death following an unscheduled admission from a nursing home.
- Unexpected postoperative deaths.
- Patients dying from postoperative complications such as
 - Sepsis, shock, hemorrhage, or vascular disease.
 - Disruption of anastomotic connections.
- Deaths from Alzheimer's disease or other dementias.
- Suicide.
- Deaths of patients on multiple pharmaceutical agents.

Consent for autopsies will be obtained by signature of the next-of-kin on the appropriate form, including any limitation imposed by the next-of-kin. Permission for donation of any organ or tissue should be included. The physician staff will provide information regarding clinical diagnosis and concerns to the pathology staff prior to the autopsy, specifically including any infection hazards.

- ii) Autopsy findings shall be included in appropriate performance improvement activities.

4. PHYSICIANS' ORDERS

A. GENERAL REQUIREMENTS.

- i) The nurse shall notify the practitioner in case of doubt. "Renew," "repeat," and "continue" previous orders are not acceptable, unless specifics are included. All previous orders will be automatically canceled when patients go to the operating room or are transferred to another service.
- ii) House staff may write orders for patient care in accordance with the foregoing rules and regulations and center policy on resident supervision.

B. MEDICATION ORDERS.

- i) All Medical Staff will be familiar with current, applicable medical center policy memoranda regarding the prescription, dispensing, and administering of drugs. Administration time or time intervals between doses are required on all prescriptions and medication orders. Compliance with the policies and procedures outlined in those memoranda will be strictly enforced.
- ii) Anticoagulant drugs should be ordered specifically as to dosage, time, and route of administration. The order will be promptly reviewed and acted upon after 3 days.
- iii) Patients bringing their own medications into the hospital shall not have this medication administered unless specifically ordered by the patient's attending physician.

C. Laboratory Orders

- i) Blood drawn for cross-matching in anticipation of blood transfusion shall be placed only in tubes labeled at the time of venipuncture with the patient's name, social security number, date, and initials of two individuals verifying the patient identity against wrist band, as per CPM F-113-01, Blood Transfusion.
- ii) Specimens will be accepted and analyzed only with a valid order by a member of the organized medical staff or other persons authorized under law and VHA policy.

D. STANDING ORDERS. There will be no standing or routine orders.

E. AUTOMATIC STOP ORDERS. Automatic stop orders for drugs are described in CPM F-119-6, Drug Policy.

F. VERBAL ORDERS. Verbal/telephone orders are limited to emergencies and to circumstances when in the opinion of the physician, having the physician input the orders into the computer would significantly delay necessary medical care of the patient. Verbal orders for the routine admission or discharge process, routine testing, and routine medications are unacceptable.

- i) In the management of emergency circumstances when the urgency of the clinical situation requires verbal orders; e.g., during cardiopulmonary resuscitation.
- ii) When orders are not practical; e.g., when patient interest is best served by verbal order to enhance efficiency of care.
- iii) In all circumstances where verbal orders are given, they may be accepted and transcribed only by registered nurses, registered respiratory therapists, or pharmacists. The full range of authority and restrictions are described CPM F-118-13, "Verbal Ordering Inpatient/Community Living Center Service." All Medical Staff members will be familiar with this policy and conform to its requirements. Verbal orders, as well as seclusion or restraint (including chemical restraints) and suicide precautions should be written in the chart as soon as possible and authenticated by the practitioner's signature within 24 hours.
- iv) Verbal orders will be written and read back to ensure accuracy.

G. INVESTIGATIONAL DRUGS. May be used only when approved by the Research and Development Committee and the CEB. They will be administered under an approved protocol with patient informed consent and under the supervision of the authorized principal investigator. Approved protocols are not required when investigational drugs are used for humanitarian reasons; however, approval by the Research & Development Committee and CEB is still required.

H. INFORMED CONSENT. Except in specific instances, treatment plan diagnostic and therapeutic endeavors will be undertaken only with the prior informed, voluntary consent on the part of the patient. The principle of informed consent will be uniformly applied as outlined in CPM F-125-20 "Informed Consent for Clinical Treatments and Procedures".

I. SUBMISSION OF SURGICAL SPECIMENS. All tissue and material removed during an operation shall be sent to the hospital pathologist who shall make such examination, or disposition, as he may consider necessary to arrive at a pathological diagnosis, and he shall sign the report. Bone marrow smears may be interpreted by either specially trained internists or pathologists. The physician's signed report shall be made a part of the patient's medical record as soon as possible. All tissue shall remain the property of the hospital under the custody of the Chief, Pathology & Laboratory Medicine Service.

J. REVIEW OF OUTSIDE PATHOLOGICAL MATERIAL. When patients are scheduled to undergo elective treatment (including surgery, radiation therapy, or chemotherapy) based on tissue samples obtained elsewhere, representative tissue material must be reviewed by a pathologist at this medical center and the diagnosis confirmed. The elective treatment/procedure should not be performed until confirmation of the diagnosis has been obtained.

K. SPECIAL TREATMENT PROCEDURES.

i) Life Sustaining Treatment.

(a) Cardiopulmonary Resuscitation (CPR) will be administered to patients who sustain cardiopulmonary arrest, except when resuscitation would be futile or useless or when medical records contain advance directives which describe the patient's or surrogate decision-maker's wishes to institute "do not resuscitate" (DNR) orders. Specific policies and procedures regarding the role of the physician, the family, conflict resolution, decision-making mechanisms, and record documentation are outlined in CPM F-123-14 Cardiopulmonary Arrest – "Code Blue" and F125-16 "Do Not Resuscitate" (DNR))

(b) The center policy and procedures regarding CPR are detailed in CPM F-11 14, Policy for "Cardiopulmonary Arrest – "Code Blue". CPM F-123-14 "Cardiopulmonary Arrest – "Code Blue" All members of the Medical Staff must be familiar with and conform to this policy.

ii) Protective Security.

(a) Care of confused, combative, or emotionally disturbed patients may necessitate the use of restraints. Such measures shall be used only in a protective and therapeutic mode to prevent the patient from causing physical harm to self or others.

(b) The use of mechanical restraints and/or seclusion will be kept to a minimum

and used as a last resort, when all other intervention and treatment modalities have failed and are so documented. (See CPM F-118-25," Restraint and/or Seclusion of Patients.")

- Restraint: Any method of physically restricting a person's freedom of movement, physical activity, or normal access to his/her body.
 - Seclusion: The involuntary confinement of a patient alone in a room, which the patient is physically prevented from leaving, for any period of time.
- (1) A Licensed Independent Practitioner's (LIP) written order will be required for such measures and must specify the length of time, not to exceed four hours, and have basis for use documented in clinical justification.
 - (2) The observation and assessment of patients in seclusion must be documented at intervals no longer than every 15 minutes.
 - (3) In an emergency situation for behavioral health reasons where the LIP is not immediately available, a registered nurse may initiate restraint and seclusion without the LIP's order, if the nurse has assessed the patient and is qualified by training and experience in the proper use of restraint and seclusion. The LIP must assess the patient within four hours of being placed in restraints.
 - (4) In order for an emergent initiated restraint or seclusion to be continued, the LIP must write a specific order and progress note within four hours after the restraint or seclusion initiation. If the patient is no longer in restraints or seclusion when the original verbal order expires, the LIP conducts an in-person evaluation within 24 hours of the initiation of the restraints or seclusion.
 - (5) If the patient is continued in restraint or seclusion more than four hours, reevaluation of the patient will take place every four hours by a designated trained, competent caregiver. A LIP will conduct an in-person reevaluation every eight hours.
 - (6) An LIP's written order will be requested to initiate protocols for medical protective devices employed on acute Medical and Surgical units.
- iii) Emergency commitment.** In an emergency, any Medical Staff physician may hold a patient for commitment until the next duty day. The physician will immediately notify Police Service and will not leave the patient until they are on the scene. Data for the affidavit for commitment should be recorded immediately, to capture an

accurate description of the actual behavior (where, when, how long and names of witnesses who observed facts). These procedures will immediately be coordinated with Mental Health Service. All commitment actions shall be guided by CPM C-136-03; Commitment under Mississippi State Laws.

- iv) **Incident reporting.** The Medical Staff must be sensitive and responsive to the requirements for incident reporting as described in CPM A-00-31, Reports of Incidents Involving a Patient or Other Beneficiary. It is the policy of the medical center that all incidents or alleged incidents be reported and adequately reviewed, including an investigation if indicated.
- v) **Multidisciplinary treatment.** When a team approach is used in the treatment of a patient, the areas of responsibility and authority, together with the functional role of the team, should be documented and approved within the service. In every case, even though authority to perform certain acts may be delegated to various team members, the ultimate responsibility for diagnosis and treatment of a patient remains with the physician, and thus the physician must participate in and sign any treatment plan development.

5. ROLE OF ATTENDING STAFF

A. Supervision of Residents.

- i) **Supervision of Residents.** Residents are individuals assigned to the medical center for the primary purpose of receiving post-graduate training and education and who participate in patient care under the direction of VA staff physicians/dentists who have clinical privileges in the areas supervised. Thus, patient care is an inherent component of their assignments. The scope and degree of their involvement in the care of a patient will be commensurate with their demonstrated knowledge, judgment, and health care skills.
 - (1) Appropriate supervision includes examination of the patient, discussion of the findings and therapeutic options, development of a plan for medical care, and execution of this plan to completion of the episode of care.
 - (2) Responsibility for the care of each patient lies with the staff physician/dentist to whom the patient is assigned; and supervision of residents providing care is, likewise, the responsibility of the staff physician. The staff physician will fulfill this responsibility by active participation in the patients' care and by sufficient documentation in the patients' chart to substantiate the participation.
 - (3) Ultimately the effectiveness of this program rests with first-line supervisors, the service chiefs, and staff physicians who supervise residents. All participants shall be guided by the provisions of VA Handbook 1400.1; Resident Supervision.
 - (4) A patient care order written by a member of the Medical Staff shall take

precedence over an order written by house staff.

B. Documentation of Supervision.

- i) Sufficient evidence will be documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician within 24 hours of admission at the time of any significant change in clinical course or therapeutic plan, prior to any invasive procedure, and critical changes in the patients' condition that may warrant a change in the diagnostic and/or treatment plans. Frequency shall otherwise be guided by the nature of the patient's condition, complexity of the case, the experience of the individual being supervised, and to adequately substantiate the participation.
- ii) Entries in the medical record, made by house staff that requires countersigning by supervisory or attending Medical Staff members are the Discharge Summary, History and Physical Exam, Treatment Plan, and surgical operations reports.
- iii) The CEB will, at intervals, review and approve minutes of the Residency Review Board and monitoring instruments used to evaluate residency supervision.

6. MEDICAL RECORDS

- A.** An authorized physician or dentist must collect and record a sufficient database to provide optimal care for each patient. All dental patients must receive the same basic medical appraisal by a physician as patients admitted for other services.
- B.** Records will be created and maintained in an acceptable, systematic manner for each patient treated.
- C.** Consultant's notes shall be written or typed and shall express a specific opinion relevant to the patient for the purpose requested. The consultation report should state that the medical record was reviewed by the consultant.
- D.** Nursing and laboratory observations will be included in the medical record, according to published policy.
- E.** Progress of the patient must be recorded at a frequency appropriate to the clinical circumstances of the patient and include physician's evaluation of therapies provided the patient.
- F.** The clinical resume should recapitulate concisely the reason for the hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and the specific instructions given to the patient and/or family, particularly in relation to physical activity, ability to return to work, medication, diet, and follow-up care.

- G. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission. This resume is to be prepared before discharge from the hospital, except for AMA and death discharges. The therapy, which the patient received, must be described sufficiently so that another practitioner can assume responsibility for the care at any time without adversity to the patient.
- H. Respiratory care services must be documented in the patient's medical records in relation to the type of therapy, dates, and times of administrations, specifications of the prescriptions, effects of therapy, including any adverse reactions; and a physician's entry must describe the timely pertinent clinical evaluation and results of therapy.
- I. The attending staff member or house staff officers shall write onto the medical record of each patient, as soon after admission as possible, the following:
 - i) The provisional diagnosis or recognized problems.
 - ii) An initial progress note stating the cause of hospitalization, his clinical findings, and the course of treatment contemplated.
 - iii) A complete history and physical examination within 24 hours after admission.
Signatures with appropriate title e.g., M.D.
- J. History and physical examinations, performed by medical students, and dental residents shall be edited, amended as necessary, and countersigned by licensed house staff or attending physician. All entries reflecting medical opinion by medical students or unlicensed house staff must be countersigned by the involved licensed house staff or attending physician.
- K. The medical record must contain documentation to the effect that a staff person has seen the patient and concurs in the diagnosis and treatment plan. The staff representative must also support his continued supervision of the resident by appropriate documentation on the chart.
- L. All records are the property of the G. V. (Sonny) Montgomery VA Medical Center, Jackson, Mississippi, and cannot be removed from the premises, except:
 - i) When the patient is receiving services elsewhere under this hospital's auspices;
 - ii) Under court order, statute subpoena; or
 - iii) Conditions consistent with VHA Handbook 1907."Health Information Management and Health Records."
- N. Free access to all medical records of all patients shall be afforded to Medical Staff for

bona fide study and research, which has been approved by the Research and Development Committee (R&D) consistent with preserving the confidentiality of personal information concerning the individual patient, in accordance with the Privacy Act of 1975.

- O. Medical records will be completed at the time of discharge, including progress notes, diagnosis, and discharge note. All summaries shall be signed by the attending staff member or his designee.
- P. Discharge summaries, with the exception of AMA and death summaries, must be dictated prior to discharge.
- Q. Medical records not completed at discharge will be completed within 30 calendar days.
- R. Medical records for outpatient visits must be completed within one day of the encounters.
- S. The Medical Records Committee will establish a list of acceptable abbreviations and symbols, and a list of unacceptable dangerous abbreviations not to use in the medical record approved by CEB.
- T. Provisional (anatomic) autopsy diagnoses must be made part of the patient's medical record within 1 day, and the final/complete necropsy protocol within 30 workdays.
- U. Individuals approved to document in the medical record are designated in attachment.
- V. Medical records shall not be permanently filed until they are completed by the Medical Staff member, or his designee, who has knowledge of the patient and his care, or ordered filed by the Medical Record Administrator (according to the procedure outlined by the Medical Records Committee).
- W. A medical record is determined to be complete when the required contents are assembled and authenticated including any complication, the required clinical resume and final progress note. Completeness implies the transcription of any dictated record content and its insertion into the medical record.
- X. Staff members, who fail to complete their assignments, including records, will be subject to disciplinary actions according to VA procedure outlined in VHA Human Resources 5000 series.
- Y. Members of the medical staff and other practitioners, as determined by the Medical Records Committee, and approved by the CEB, have authority to enter information into the medical record. (See attached list.)

7. INFECTION CONTROL

- A. Infection control practices will be strictly adhered to, as outlined in the Center Infection Control Manual and CPM F-111-23, Tuberculosis in the Health Care Setting.

- B. All services must document in-service education relative to infection prevention and control.
- C. There will be a regular review of the clinical use of antibiotics.
- D. The Medical Staff must actively participate in the study of hospital-associated infections and infection potential and must promote a preventive and corrective program designed to minimize those hazards.
- E. The review of patient care shall contain an infection control/isolation area or criteria when pertinent to the monitoring and evaluation.

8. CONTINUING EDUCATION

- A. A program of continuing education must be designed to keep the Medical Staff informed of significant new developments and skills in the health care professions.
- B. Medical Staff education should include hospital based programs, planned, scheduled in advance and held on a continuing basis and educational opportunities held outside the hospital.
- C. Documentation of continuing education activities will be maintained.
- D. Members of the Medical Staff are encouraged to attend continuing educational meetings, conferences, or symposia at the hospital or elsewhere to maintain or upgrade professional skills. The Office of Education will maintain records of continuing medical education for all staff members who are employed half-time or more. Each year, a Continuing Education record form will be sent to such staff members for their completion and return to the education office.
- E. Medical Staff assigned to a particular service must attend their service meetings, unless excused by the service chief.
- F. All orientation and in-service education programs will be specific to the employee's function.
- G. Medical staff members must have a minimum of 16 American Medical Association Category I, or II or equivalent continuing education hours documented annually.

9. HEALTH STATUS AND IMPAIRED PROFESSIONAL PROGRAM

- A. Medical staff will receive education on recognizing signs and symptoms of illnesses and impairments, which occur at increased frequency in health professionals at their initial employment and at intervals as necessary.
- B. Referrals of medical staff providers with suspected illnesses or impairments by self or

others may be made to the appropriate service chief, Employee Assistant Program, or the Chief of Staff.

- C. All referrals will be confidential and may not be used for disciplinary action except as limited by law, ethical obligations, or when to patient safety is threatened.
- D. In circumstances where the credibility of the allegation or concern is sustained, appropriate monitoring of the affected medical staff provider's practice will be initiated to assure patient safety until the rehabilitation process is complete and periodically thereafter, if required.
- E. Any findings of unsafe medical care will be reported to medical staff leadership.

10. PEER REVIEW

The Medical Staff shall participate in a protected peer review process. A peer review committee is established and appropriate education will be provided to all participants of the protected peer review process prior to participating in a review with refresher training biennially. The protected peer review process is outlined in CPM A-11Q-41 "Peer Review for Quality Management" and VHA Directive 2010-025 "Peer Review for Quality Management".

11. RULES OF SURGICAL CARE

- A. Major surgical operations, other than emergency, shall not be performed until all adequate clinical and laboratory data are obtained, including physical exam and medical history indicating diagnosis, tests, and determinations of a preoperative diagnosis.
- B. Written, signed informed surgical consent shall be obtained prior to any operative procedure, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving an unconscious patient in whom consent for surgery cannot be immediately obtained from next-of-kin, these circumstances should be fully explained on the patient's medical record. The Chief of Staff must be consulted for his concurrence and has the authority to approve the operation. VA forms and procedures will be used as described in CPM F-125-20, "Informed Consent for Clinical Treatment and Procedures." In procedures where it is anticipated that blood is likely to be used, patients must receive pre-operative informed consent for the administration of blood and blood products.
- C. In a surgical procedure with unusual hazards to life, there must be a qualified assistant present or immediately available. Medical students should act only in a second, third, or fourth assistant capacity at major operative procedures.
- D. Medical and dental students may be permitted to perform minor surgery such as closure of minor wounds, minor excision of cysts, etc., only when under the direct supervision of

a Medical Staff member and with the permission of the patient, with full knowledge that the operator is a student. Records will reflect the true status of the surgical team.

- E. Anesthesiology Service shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthetic follow-up of the patient's condition, both in the recovery room and after his return to the ward.
- F. All surgical operations shall be fully described and recorded immediately by the responsible surgeon or his designee. The operative note shall include the indications for and findings at operations, as pertinent, as well as the technical description of the procedure.
- G. There shall be written guidelines developed by an anesthesiologist for the safe use of all general anesthetic agents used in the hospital. When the operating anesthesia team consists entirely of non-physicians; for example, dentists with nurse anesthetists, a physician must be immediately available in case of emergency such as cardiac standstill or cardiac arrhythmia.
- H. The release of every patient from the post anesthesia care unit must be based on a physician's decision or RNs using approved protocols.
- I. There must be evidence in the medical record of a post anesthesia visit which is made after the patient has left the post anesthesia care unit and describes the presence or absence of anesthesia-related complications. In addition, each post anesthesia note should specify the date and time of the visit.
- J. Post anesthesia care unit medical information should include vital signs, level of consciousness on entering and leaving the recovery area, status of infusion, status of surgical dressings, and status of any tubes, catheters or drains.

12. DISASTERS

Mass casualty assignments for Medical Staff will contain the assignment to posts within the hospital (and off-station triage sites and/or teams), and it is the responsibility of the Medical Staff member to report to his assigned station when needed. The Chief of Staff and Center Director will work as a team to coordinate activities and direction. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises; the Chief of Staff, during the disaster, will authorize movement of patients as directed by the Center Director or his designee. All policies concerning patient care will be the responsibility of the Chief of Staff or Center Director, or in their absences, the Acting Chief of Staff and Associate Director.

13. QUALITY of PROFESSIONAL SERVICE

- A. Ambulatory care services and the Nursing Home Care Unit shall meet the same standards of quality as apply to inpatient care. This standard recognizes the inherent differences

between inpatients, Nursing Home Care Unit residents, and outpatients with respect to their needs and modes of treatment.

- B. The quality of care provided in the outpatient service will be reviewed and evaluated by the Ambulatory Care Committee.
- C. Evaluation of the efficiency and effectiveness of ancillary patient services shall be carried out systematically in an objective manner and appropriately documented. Overall responsibility for the quality of medical care rests with the Medical Staff.
- D. There shall be a program of systematic professional and administrative review and evaluation of each service's effectiveness in relation to its stated mission and objectives.
- E. The quality of patient care shall be evaluated by members of the Medical Staff and other members of the professional staff directly responsible for patient care. Criteria must be explicit and measurable and must reflect the optimal level of care that can be achieved through current medical and related health science knowledge.
- F. Variations in the quality of care that are not justified to peer satisfaction must be analyzed. If analysis indicates inappropriate pattern of patient care, action must be taken to correct the problem. Such actions must be specific to the problem and may include educational or training programs, amended policies or procedures, increased or realigned staffing, provision of new equipment or facilities, or adjustments in clinical privileges.
- G. The entire patient-care evaluation activity must be documented and its results reported. The evaluation activity shall be continuous and shall be comprehensive of conditions and problems treated and procedures performed.
- H. Members of the medical staff are involved in activities to measure, assess, and improve organizational performance through a peer review process as specified in center policy.

14. PERFORMANCE IMPROVEMENT

- A. The medical staff has a leadership role in the performance improvement processes and activities as specified in the medical center Performance Improvement Plan.
- B. The medical staff will be actively involved in measurement assessment and improvement of processes which depend on the activities of one or more licensed independent practitioners in the following areas:
 - i) Medical assessment and treatment of patients
 - ii) Use of information about adverse privileging decisions for a practitioner privileged through the medical staff process.
 - iii) Use of medications.
 - iv) Use of blood and blood components.
 - v) Operative and other procedures.

- vi) Appropriateness of clinical practice patterns.
 - vii) Significant departures from established patterns of clinical practice.
 - viii) The use of developed criteria for autopsies.
 - ix) Sentinel event data.
- C. The medical staff will be actively involved in organization wide measurement assessment and improvement of processes which depend on the activities of:
- i) Education of patients and families.
 - ii) Coordination of care, treatment, and services with other practitioners and hospital personnel as relevant to the care, treatment, and services of an individual patient.
 - iii) Accurate, timely, and legible completion of patient's medical records.
 - iv) Findings of the assessment process that is relevant to an individual's performance and determining the use of this information in the ongoing evaluation of a practitioner's competence.
 - v) Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

15. PATIENT SAFETY

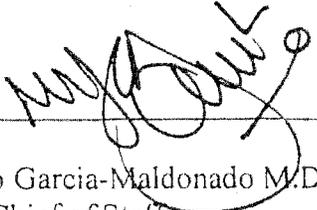
- A. The medical staff shall participate in processes and activities that make the care environment safe and effective by reducing and controlling environmental hazards and risks by preventing accidents and injuries, and by maintaining safe conditions for patients, visitors, and staff as specified by published medical center policy memoranda.
- B. Safety processes include safety management, security management, hazards materials and waste management, medical equipment management and utility systems management as specified in published medical center policy memoranda.

16. PATIENT SATISFACTION

The Medical staff shall participate in the analysis of patient satisfaction data and the development of processes and activities to improve patient satisfaction. Activities to improve patient satisfaction will be in accordance with the medical center Performance Improvement Plan.

Adopted by the Medical Staff on
Dated: 9/28/2012

Adopted by the Center Director on
Dated: 9/29/12



Maurilio Garcia-Maldonado M.D.
Acting Chief of Staff



Joe D. Battle
Center Director

Attachment A

INDIVIDUALS/DISCIPLINES APPROVED TO DOCUMENT IN THE MEDICAL RECORD

A&MMS Purchasing Agent
Addiction therapists
American Association of Pastoral Counseling Program Students
Administrative Assistants to Clinical Service Chiefs
Audiologists
Certified Registered Nurse Anesthetists
Staff Chaplains
Chief Prosthetics & Sensory Aids Service
Chiropractors
Contract Program Assistant
Clinical Pastoral Education Program Residents
Cytotechnologist
Dental Hygienists
Dentists
Diet Technicians
Dietitians
Health Science Specialist
Health Technicians
Licensed Practical Nurses
Medical Administration Service Personnel
(Senior) Medical Students and Nursing Students with co-signature
Medical Support Assistants
Medical Technician
Medical Technologist
Neuro-diagnostics technologists
Nuclear Medicine Technologists
Nurse Practitioners
Nursing Assistants
Occupational Therapists
Occupational Therapy Assistants
Patient Service Assistants
Pharmacists
Physical Therapists
Physical Therapy Assistants
Physician Assistants
Physicians
Podiatrists
Program Support Assistants
Psychologists

Psychology Technicians
Psychology Interns and Psychology Postdoctoral Fellows with co-signature
Radiology Technicians
Recreational Therapists
Registered Nurses
Respiratory Therapists
Social Workers
Social Work students with co-signature
Speech Pathologists
Vocational Counselors

CREENTIALING AND PRIVILEGING

1. REASON FOR ISSUE. This revised Veterans Health Administration (VHA) Handbook provides VHA procedures regarding credentialing and privileging.

2. SUMMARY OF CONTENTS/MAJOR CHANGES. This revision of VHA Handbook 1100.19 incorporates:

a. VHA policy on participation and actions related to the National Practitioner Data Bank (NPDB) including participation in the Proactive Disclosure Service and changes concerning second level review by the Veterans Integrated Service Network Chief Medical Officer of the appointment and privileging process.

b. Clarification of identified issues related to verification and follow-up of State licenses, including a requirement for written verification of licensure in follow-up to other methods of verification, as well as timely follow-up of actions taken by State licensing boards. Specific guidance is provided for those instances where a practitioner enters into an agreement to not practice in a State.

c. The educational requirement for facility medical staff leaders to complete training in Medical Staff Leadership and Provider Profiling within 3 months of assuming the position.

d. The Focused Professional Practice Evaluation and ongoing monitoring of privileges, as well as clarifies information on practitioner specific information to be compiled in the provider profile and evaluated as part of the facility's ongoing monitoring of practitioner health care practice, as well as for the reappraisal and privileging process.

e. Sample letters for the Summary Suspension of Privileges, Automatic Suspension of Privileges, and Clinical Practice Review.

3. RELATED ISSUE. VHA Directive 1100 (to be published).

4. RESPONSIBLE OFFICE. The Office of Quality Performance (10Q), is responsible for the contents of this VHA Handbook. Questions may be addressed to (919) 993-3035, extension 236.

5. RESCISSIONS. VHA Handbook 1100.19, dated October 2, 2007, is rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of November 2013.

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

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CREDENTIALING AND PRIVILEGING

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides VHA procedures regarding credentialing and privileging of all health care professionals who are permitted by law and the facility to practice independently. *NOTE: This Handbook does not apply to residents, except those who function outside the scope of their training program; i.e., Admitting Officer of the Day.*

2. SCOPE

a. All VHA health care professionals who are permitted by law and the facility to provide patient care services independently must be credentialed and privileged as defined in this Handbook. The requirements of The Joint Commission (TJC) standards and VHA policies have been used to define the processes for credentialing, privileging, reappraisal, re-privileging, and actions against clinical privileges, including denial, failure to renew, reduction, and revocation. This Handbook applies to all VHA licensed independent practitioners permitted by law and facility to provide direct patient care, including telemedicine, and who are appointed or utilized on a full-time, part-time, intermittent, consultant, attending, without compensation (WOC), on-station fee-basis, on-station contract, or on-station sharing agreement basis. The credentialing, but not privileging, requirements of this Handbook apply to all Advanced Practice Registered Nurses (APRN) and Physician Assistants (PA) even though these practitioners may not practice as licensed independent practitioners, as well as physicians, dentists, and other practitioners assigned to research or administrative positions not involved in patient care.

b. Policy and procedures related to the denial, failure to renew, reduction, and revocation of clinical privileges, where based on professional competence, professional misconduct, or substandard care, apply to all health care professionals who are granted privileges within the scope of this Handbook.

c. VetPro is VHA's electronic credentialing system and must be used for credentialing all providers who are granted clinical privileges or are credentialed for other reasons. One component of VHA's Patient Safety Program is quality credentialing and the use of VetPro is necessary to reduce the potential for human error in the credentialing process. In addition, documentation other than in VetPro that is required by this Handbook must be maintained in a paper or electronic medium. The requirements of this policy are the same whether carried out on paper or electronically. For example, if a signature is required and the mechanism in use is electronic, then that modality must provide for an electronic signature.

d. Credentialing and privileging must be completed prior to initial appointment or reappointment to the medical staff and before transfer from another medical facility. If the primary source verification(s) of the practitioner's credentials are on file (paper or electronic), those credentials that were verified at the time of initial appointment (and are not time-limited or specifically required by this policy or TJC to be updated or re-verified) can be considered verified.

e. All procedures described in this Handbook are applicable to Chiefs of Staff (COS) and facility Directors who are involved in patient care. Differences in specific procedures are noted where applicable.

f. This policy applies to licensed health care personnel in VHA Central Office, Veterans Integrated System Network (VISN) offices, and other organizational components that would be credentialed in accordance with this policy if in a VA facility, to include but not limited to physicians, dentists, advanced practice nurses, and physician assistants.

NOTE: In those instances where the VISN Chief Medical Officer (CMO) is not a physician, the CMO must be credentialed in accordance with this policy.

NOTE: Wherever the policy defines an action or responsibility of the medical facility Director, or designee, that role belongs to the head of that organizational component, or designee.

g. Nothing in the VA medical center Medical Staff Bylaws, Rules, and Regulations can have any effect inconsistent with, or otherwise be inconsistent with, law, Department of Veterans Affairs (VA) regulations, this Handbook's policies and procedures, or other VA policies.

3. DEFINITIONS

a. **Appointment.** The term "appointment" refers to the medical staff. It does not refer to appointment as a VA employee (unless clearly specified), but is based on having an appropriate personnel appointment action, scarce medical specialty contract, or other authority for providing patient care services at the facility. Both VA employees and contractors may receive appointments to the medical staff.

b. **Associated Health Professional.** The term "Associated Health Professional" is defined as those clinical professionals other than doctors of allopathic, dental, and osteopathic medicine.

c. **Authenticated Copy.** The term "authenticated copy" means that each page of the document is a true copy of the original document; each page is stamped "authenticated copy of original" and is dated and signed by the person doing the authentication. *NOTE: Facsimile copies of verification documents may not be used for final verification.*

d. **Credentialing.** The term "credentialing" refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, and current competence and health status.

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

NOTE: There may be practitioners, who by the nature of their position, are not involved in patient care (i.e., researchers or administrative physicians). These health care professionals must be credentialed, but may not need to be privileged.

f. **Competency.** Competency is documented demonstration of an individual having the requisite or adequate abilities or qualities capable to perform up to a defined expectation.

g. **Current.** The term "current" applies to the timeliness of the verification and use for the credentialing and privileging process. No credential is current and no query of the Federation of State Medical Boards (FSMB) is current if performed prior to submission of a complete application by the practitioner to include submission of VetPro. At the time of initial appointment, all credentials must be current within 180 days of submission of a complete application. For reappointment, all time-limited credentials must be current within 180 days of submission of the application for reappointment including peer appraisals, confirmation of National Practitioner Data Bank (NPDB)-Health Integrity and Protection Data Bank (HIPDB) Proactive Disclosure Service (PDS) annual registration, and other credentials with expirations.

h. **Independent Practitioner.** The term "independent practitioner" is any individual permitted by law (the statute which defines the terms and conditions of the practitioner's license) and the facility to provide patient care services independently; i.e., without supervision or direction, within the scope of the individual's license and in accordance with individually-granted clinical privileges. This is also referred to as a licensed independent practitioner (LIP).
NOTE: Only LIPs may be granted clinical privileges.

i. **Licensure.** The term "licensure" refers to the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State, Territory, Commonwealth, or the District of Columbia (hereafter, "State") in the form of a license, registration, or certification.

j. **One Standard of Care.** The term "one standard of care" means that one standard of care must be guaranteed for any given treatment or procedure, regardless of the practitioner, service, or location within the facility. In the context of credentialing and privileging, the requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same.

k. **Post-graduate (PG).** The term PG is the acronym for post-graduate.

l. **Primary Source Verification.** Primary source verification is documentation from the original source of a specific credential that verifies the accuracy of a qualification reported by an individual health care practitioner. This can be documented in the form of a letter, documented telephone contact, or secure electronic communication with the original source.

m. **Proctoring.** Proctoring is the activity by which a practitioner is assigned to observe the practice of another practitioner performing specified activities and to provide required reports on those observations. The proctor must have clinical privileges for the activity being performed, but must not be directly involved in the care the observed practitioner is delivering. Proctoring

that requires a proctor 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, constitutes supervision. Such supervision may be a reduction of privileges (see the *NOTE* following subpar. 6j(2) for additional information).

n. **Teleconsulting.** Teleconsulting is 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 hands-on care is delivered at the site of the patient by a licensed independent health care provider.

o. **Telemedicine.** Telemedicine is 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.

NOTE: A crucial consideration in making a distinction between consultation and care is that teleconsultation occurs when the consultant involved recommends diagnoses, treatments, etc., to the consulting provider requesting the consult, but does not actually write orders or assume the care of the patient. If the consultant diagnoses, writes orders, or assumes care in any way, this constitutes "care" and requires privileges. A Medical Staff appointment is required if the provider is entering documentation into the medical record, e.g., teleradiology, teledermatology, etc.

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

4. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health, or designee, is responsible for ensuring the development and issuance of the VHA credentialing and privileging policy.

b. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health, or designee, is responsible for ensuring oversight in the development and implementation of VHA credentialing and privileging for licensed health care professionals in VA Central Office, VISNs, and VA Medical Centers.

c. **Deputy Under Secretary for Health for Operations and Management (10N).** The Deputy Under Secretary for Health for Operations and Management (10N), is responsible for ensuring that VISN Directors maintain an appropriate credentialing and privileging process consistent with the VHA policy. In doing so, uniform prototype performance standards will be issued for key VHA medical facility managers, such as Directors, Associate or Assistant Directors, Human Resource Management Officers, and COS. Monitoring of credentialing and privileging must continue through periodic TJC consultative site visits and other reviews, as applicable.

d. **Facility Director.** The ultimate responsibility for credentialing and privileging resides with the facility Director. The facility Director, designated by the Under Secretary for Health as the Governing Body of the facility, is responsible for ensuring:

(1) The labor-management obligations are met prior to implementing a Credentialing and Privileging Program that involves Title 5 independent practitioners who are represented by a professional bargaining unit.

(2) Local facility policy, including Medical Staff Bylaws, Rules, and Regulations, is consistent with this Handbook.

(3) Medical staff leadership and all staff with responsibility in the credentialing and privileging process complete the one-time only training as determined by the Office of Quality and Performance (OQP). Training must be completed within 3 months of assuming this position. This training may be accessed through the VA Learning Management System at <http://www.lms.va.gov>. This target audience includes: Medical Staff and Credentialing Professionals; Service and Product Line Chiefs; Credentials Committee Members (Professional Standards Boards); Medical Executive Committee Members; COSs and Medical Directors; Quality and Performance Improvement Professionals; and Risk Managers. *NOTE: Additional information may be found at EES Mandatory Training website at <http://vawww.ees.lrn.va.gov/mandatorytraining>.*

e. **Facility COS.** The facility COS is responsible for:

(1) Maintaining the Credentialing and Privileging system and ensuring that all health care professionals applying for clinical privileges agree to provide continuous care to the patients assigned to them and are provided with a copy of, and agree to abide by the Medical Staff Bylaws, Rules, and Regulations; and ensuring that the Medical Staff Bylaws are consistent with this Handbook and any other VHA policy related to Medical Staff Bylaws.

(2) Completing training identified in subparagraph 4c(3) and ensuring that appropriate staff in direct line of authority complete the training.

f. **Service Chiefs**

(1) Service chiefs are responsible for:

(a) Recommending the criteria for clinical privileges that are relevant to the care provided in the service;

(b) Reviewing all credentials and requested clinical privileges, and for making recommendations regarding appointment and privileging action; and

(c) A continuous surveillance of the professional performance of those who provide patient care services with delineated clinical privileges. *NOTE: The title Service Chief applies to Service Line Directors, Product Line Chiefs, and any other equivalent titles.*

(2) Service Chiefs involved in the credentialing and privileging process are responsible for completing training identified in subparagraph 4c(3) and ensuring that appropriate staff in direct line of authority complete the training.

g. **VISN CMO**. The VISN CMO is responsible for oversight of the credentialing and privileging process of the facilities within the VISN.

h. **Director, Management Review Service (10B5)**. The Director, Management Review Service (10B5), is responsible for evaluating progress towards the implementation of recommendations made by external reviewers, such as Office of Inspector General (OIG) and Government Accountability Office (GAO).

i. **Applicant and Practitioner**. Applicants and appointed practitioners must provide evidence of licensure, registration, certification, and/or other relevant credentials, for verification prior to appointment and throughout the appointment process, as requested. They must agree to accept the professional obligations delineated in the Medical Staff Bylaws, Rules, and Regulations provided to them. They are responsible for keeping VA apprised of anything that would adversely affect, or otherwise limit, their clinical privileges.

NOTE: Failure to keep VA fully informed on these matters may result in administrative or disciplinary action.

5. CREDENTIALING (i.e., the Initial Appointment, Reappointment, or Reappointment after a Break in Service)

a. **Provisions**. Health care professionals must be fully credentialed and privileged prior to initial appointment or reappointment, except as identified in subparagraphs 5o, 5p, 6e, and 6f.

b. **Procedures**. Credentialing is required to ensure an applicant has the required education, training, experience, physical and mental health, and skill to fulfill the requirements of the position and to support the requested clinical privileges. This paragraph contains the administrative requirements and procedures related to the initial credentialing and reappraisal of practitioners who plan to apply for clinical privileges.

(1) The credentialing process includes verification, through the appropriate primary sources, of the individual's professional education; training; licensure; certification and review of health status; previous experience, including any gaps (greater than 30 days) in training and employment; clinical privileges; professional references; malpractice history and adverse actions; or criminal violations, as appropriate. Except as identified in subparagraph 5a., medical staff and employment commitments must not be made until the credentialing process is completed, including screening through the appropriate State Licensing Board (SLB), FSMB, and the NPDB-HIPDB. All information obtained through the credentialing process must be carefully considered before appointment and privileging decision actions are made.

(2) The applicable service chief reviews the credentialing folder and requested privileges and make recommendations regarding appointment. The folder and recommendations are

reviewed by the credentialing committee and then submitted with recommendations to the medical staff's Executive Committee.

(3) All applicants applying for clinical privileges must be provided with a copy of the Medical Staff Bylaws, Rules, and Regulations and must agree in writing to accept the professional obligations reflected therein.

(4) The applicant has the burden of obtaining and producing all needed information for a proper evaluation of 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 questions concerning these qualifications. Failure to provide necessary information, in a reasonable time, may serve as a basis for denial of medical staff appointment and/or privileges, as defined in the facility Medical Staff Bylaws.

c. **Application Forms.** Candidates seeking appointment or reappointment must complete the appropriate forms for the position for which they are applying.

(1) All candidates, requiring credentialing in accordance with this policy, must complete an electronic submission of VetPro. VetPro's supplemental information form requests applicants to answer questions to meet TJC and VHA requirements. This supplemental information form requires the applicant to provide information concerning malpractice, adverse actions against licensure, privileges, hospital membership, research, etc.

(2) The "Sign and Submit" screen in VetPro addresses the applicant's agreement to provide continuous care and to accept the professional obligations defined in the Medical Staff Bylaws, Rules, and Regulations for the facility(ies) to which the application is being made, as well as attesting to the accuracy and completeness of the information submitted.

(3) Applicants are required to provide information on all educational, training, and employment experiences, including all gaps greater than 30 days in the candidate's history.

(4) If the delay between the candidate's application and 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 the candidate reporting for duty. Verification of a time-limited credential cannot be greater than 120 days old at the time a practitioner reports for duty. This requirement includes a response from the NPDB–HIPDB. **NOTE:** *Delays between a candidate's application and reporting for duty most frequently occur in the case of an individual for whom special waivers (i.e., visa waiver) may be required. Since these processes can be time consuming, information on the candidate's practice or non-practice during the period of delay must be obtained in order to ensure the most appropriate placement of the candidate.*

NOTE: *A copy of the appropriate application form and any supplemental form(s) are maintained electronically in VetPro and may be filed in Section I of the credentialing and privileging folder. If the applicant provides a resume or curriculum vitae, this is also filed in Section I.*

d. Documentation Requirements

(1) Each privileged health care practitioner must have a Credentialing and Privileging file established electronically in VetPro with any paper documents maintained according to the requirements of the standardized folder identified in Appendix A. Other credentialed health care providers have a credentials file maintained in the same system of records even though they may not be granted clinical privileges. *NOTE: Duplication of information documented and maintained in the electronic VetPro file for filing in the paper Credentialing and Privileging file is not necessary and is discouraged.*

(2) Information obtained, to be used in the credentialing process, must be primary source verified (unless otherwise noted) and documented in writing, either by letter, report of contact, or web verification. Facilities are expected to secure all credentialing and privileging documents. Any facsimile copy must be followed up with an original document. *NOTE: When using an Internet source for verification, the following criteria must be considered in determining appropriateness as primary source verification: (a) The web site disclaimer needs to be reviewed to determine the organization's attestation to the accuracy and timeliness of the information. If there is no disclaimer, the web verification needs to seriously be considered as not adequate for verification. (b) There must be evidence that the site is maintained by the verifying entity and that the verification data cannot be modified by outside sources. If not maintained by the verifying entity, the site must include an endorsement by the entity that the site is a primary source verification or the transmission is in an encrypted format. (c) The site must provide information on the status of license and adverse action information. (d) To avoid issues arising with surveyors, it's advisable to print the disclaimer when the verification is printed. Sites are constantly changing.*

(3) There must be follow-up of any discrepancy found in information obtained during the verification process. The practitioner 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.

(4) Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and of informing the facility Director, Program Chief Officer, or designee, of any changes in the status of these credentials. The Director, Program Chief Officer, or designee, is responsible for establishing a mechanism to ensure that multiple licenses, registrations, and/or certifications are consistently held in good standing or, if allowed to lapse, are relinquished in good standing. The practitioner is required to provide a written explanation for any credentials that were held previously, but which are no longer held or no longer full and unrestricted. The verifying official must contact the State board(s) or issuing organization(s) to verify information provided regarding the change. *NOTE: There are circumstances when verification from a foreign country is not possible or could prove harmful to the practitioner and/or family. In these instances, full documentation of efforts and circumstances, including a statement of justification, is to be made in the form of a report of contact and filed in the Credentialing and Privileging file in lieu of the document sought.*

(5) If the search for documents is unsuccessful or the primary source documents are not received, after a minimum of two requests, full written documentation of these efforts, in the form of a report of contact, must be placed in the folder in lieu of the document sought. It is suggested that no more than 30 days elapse before the attempt is deemed unsuccessful. The practitioner needs to be notified and to assist in obtaining the necessary documentation through a secondary source.

e. **Educational Credentials**

(1) **Verification of Educational Credentials**

(a) For health care professionals who are requesting clinical privileges, primary source verification of all residencies, fellowships, advanced education, clinical practice programs, etc., from the appropriate program director or school is required. If a physician or dentist participated in an internship(s) equivalent to the current residency years PG 1, 2, and 3, it is necessary to obtain primary source verification of the internship(s). Any fees charged by institutions to verify education credentials are to be paid by the facility.

(b) For foreign medical school graduates, facility officials must verify with the Educational Commission for Foreign Medical Graduates (ECFMG) that the applicant has met requirements for certification, if claimed. The ECFMG is not applicable for graduates from Canadian or Puerto Rican medical schools. Documentation of completion of a "Fifth Pathway" may be substituted for ECFMG certification. Additionally, TJC accepts the primary source verification of ECFMG for foreign medical school graduation. Documentation of this verification must meet the requirements of this policy.

(c) All efforts to verify education must be documented if it is not possible to verify education, e.g., the school has closed, the school is in a foreign country and no response can be obtained, or for other reasons. In any case, facility officials must verify and document that candidates meet appropriate VA qualification standard educational requirements prior to appointment as an employee. *NOTE: VA medical treatment facilities are encouraged to consider additional information concerning the education of the applicant from other authoritative sources.*

(d) Applicants are required to provide information on all educational and training experiences, including all gaps greater than 30 days in educational history. Primary source verification must be sought on medical, dental, professional school graduation, and all residency(ies) and fellowship(s) training, as well as internships for non-physician and non-dentist applicants.

(e) An educational institution may designate an organization as its agent for primary source verification for the purposes of credentialing. The verification from the agent is acceptable (e.g., National Student Clearinghouse). Documentation of this designation needs to be on file.

(f) For other health care providers, at a minimum, the level of education that is the entry level for the profession or permits licensure must be verified, as well as all other advanced

education used to support the granting of clinical privileges, if applicable (e.g., for an APRN, the qualifying degree for the registered nurse (RN) and the advanced APRN education must be verified).

(g) Primary source verification of other advanced educational and clinical practice program is required if the applicant offers this credential(s) as a primary support for requested specialized clinical privileges.

(2) **Educational Profile for Physicians.** Facilities may obtain, from the American Medical Association (AMA) or the American Osteopathic Association (AOA) Physician Database, a profile listing of all medical education a physician candidate has received in this country. These data sources contain other information for follow-up, as necessary. The AMA Physician Masterfile is a TJC-designated equivalent for primary source verification requirements for physicians' and osteopaths' education and completion of residency training. **NOTE:** *The AOA Physician Database is a designated equivalent for: pre-doctoral education accredited by the AOA Bureau of Professional Education, post-doctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic Board certification.* In instances where these profiles do not stipulate primary source verification was obtained, the facility must pursue that verification, if required by this policy. If a VA facility elects to use the profile, any associated fee is borne by the facility. Nothing in this Handbook regarding the AMA Physician Profile or AOA Osteopathic Physician Profile alters Human Resources Management's documentation requirements for employment.

(3) **Filing.** Verification of all education and training is filed in Section III of the Credentialing and Privileging Folder and in the appropriate portion of VetPro.

f. **Verifying Specialty Certification**

(1) **Physician Service Chiefs**

(a) Physician service chiefs must be certified by an appropriate specialty board or possess comparable competence. For candidates not board-certified, or board certified in a specialty(ies) not appropriate for the assignment, the medical staff's Executive Committee affirmatively establishes and documents, through the privilege delineation process, that the person possesses comparable competence. If the service chief is not board certified, the Credentialing and Privileging file must contain documentation that the individual has been determined to be equally qualified based on experience and provider specific data. Appointment of service chiefs without board certification must comply with the VHA policy for these appointments as appropriate.

(b) Verification must be from the primary source by direct contact or other means of communication with the primary source, such as by the use of a public listing of specialists in a book or Web site, or other electronic medium as long as the listing is maintained by the primary source and there is no disclaimer regarding authenticity. If listings of specialists are used to verify specialty certification, they must be from recently issued copies of the publication(s), and include authentic copies of the cover page indicating publication date and the page listing the practitioner. This information must be included in the practitioner's folder (electronic or paper) as follows:

1. Physicians. Board certification may be verified through the Official ABMS Directory of Board Certified Medical Specialists, published by the American Board of Medical Specialists (ABMS), or acceptable Internet verification, or by direct communication with officials of the appropriate board. A letter from the board addressed to the facility is acceptable for those recently certified. The electronic matching through VetPro is primary source verification because it is performed through an electronic version of Official ABMS Directory of Board Certified Medical Specialists. Osteopathic board certification may be verified through the AOA Physician Database. Copies of documents used to verify certification are to be filed in the Official Personnel Folder and in the credentialing and privileging file. **NOTE:** *The address and telephone number of the board may be obtained from the latest Directory of Approved Residency Programs published by the Accreditation Council for Graduate Medical Education.*

2. Dentists. Board certification may be verified by contacting the appropriate Dental Specialty Board. **NOTE:** *Addresses of these boards may be obtained from the American Dental Association (ADA).*

3. Podiatrists. The following three specialties are currently recognized by the House of Delegates, American Podiatric Medical Association, and VA: the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics, and the American Board of Podiatric Public Health. **NOTE:** *Addresses of these boards may be obtained from the latest American Podiatric Directory.*

4. Other Occupations. Board certification and other specialty certificates must be primary source verified by contacting the appropriate board or certifying organization.

(2) **Evidence of Continuing Certification.** Board certification and other specialty certificates, which are time-limited or carry an expiration date, must be reviewed and documented prior to expiration.

(3) **Filing.** Verification of specialty certification is filed in Section III of the Credentialing and Privileging folder and in the Board Certification portion of VetPro.

g. Licensure

(1) **Requirement for Full, Active, Current, and Unrestricted Licensure.** Applicants being credentialed in preparation for applying for clinical privileges must possess at least one full, active, current, and unrestricted license that authorizes the licensee to practice in the state of licensure and outside VA without any change being needed in the status of the license.

NOTE: *For new appointments after a break in service, all licenses active at the time of separation need to be primary source verified for any change in status.*

(2) **Qualification Requirements of Title 38 United States Code (U.S.C.) Section 7402(f).** Applicants being credentialed for a position identified in 38 U.S.C. Section 7402(b) (other than a Director) for whom State licensure, registration, or certification is required and who possess or have possessed more than one license (as applicable to the position) are subject to the following provisions:

(a) Applicants and individuals appointed on or after November 30, 1999, who have been licensed, registered, or certified (as applicable to such position) in more than one State and who had such license, registration, or certification revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for appointment, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status.

NOTE: Covered licensure actions are based on the date the credential was required by statute or the position's qualification standards. For example, if VA first required the credential in 1972, the individual lost the credential in 1983, and the individual applies, or was appointed, to VA after November 30, 1999, the individual is not eligible for VA employment in the covered position, unless the lost or surrendered credential is restored to a full and unrestricted status. However, if the individual lost the credential in 1970, before it was a VA requirement, eligibility for VA employment would not be affected provided the individual possesses one full and unrestricted license as applicable to the position (see App. B for list of occupations, job series, type of credential, and date first required by VA).

(b) Individuals who were appointed before November 30, 1999, who have maintained continuous appointment since that date and who are identified as having been licensed, registered, or certified (as applicable to such position) in more than one State and, on or after November 30, 1999, who have had such revoked for professional misconduct, professional incompetence, or substandard care by any of those States, or voluntarily relinquished a license, registration, or certification in any of those States after being notified in writing by that State of potential termination for professional misconduct, professional incompetence, or substandard care, are not eligible for continued employment in such position, unless the revoked or surrendered license, registration, or certification is restored to a full and unrestricted status.

NOTE: Individuals who were appointed prior to November 30, 1999, and have been on continuous appointment since that date are not disqualified for employment by any license, registration, or certification revocations or voluntary surrenders that predate November 30, 1999, provided they possess one full and unrestricted license as applicable to the position.

(c) Where a license, registration, or certification (as applicable to the position) has been surrendered, confirmation must be obtained from the primary source that the individual was notified in writing of the potential for termination for professional misconduct, professional incompetence, or substandard care. If the entity does verify written notification was provided, the individual is not eligible for employment unless the surrendered credential is fully restored.

(d) Where the State licensing, registration, or certifying entity fully restores the revoked or surrendered credential, the eligibility of the provider for employment is restored. These individuals would be subject to the same employment process that applies to all individuals in the same job category who are entering the VA employment process. In addition to the credentialing requirements for the position, there must be a complete review of the facts and circumstances concerning the action taken against the State license, registration, or certification

and the impact of the action on the professional conduct of the applicant. This review must be documented in the licensure section of the credentials file.

(e) This policy applies to licensure, registration, or certification required, as applicable, to the position subsequent to the publication of this policy and required by statute or VA qualification standards, effective with the date the credential is required.

(3) When a practitioner enters into an agreement (disciplinary or non-disciplinary) with a State licensing board to not practice the occupation in a State, the practitioner is required to notify VA of the agreement. VA must obtain information concerning the circumstances surrounding the agreement. This includes information from the primary source of the specific written notification provided to the practitioner, including, but not limited to: notice of the potential for termination of licensure for professional misconduct, professional incompetence, or substandard care. If the entity does verify written notification was provided, all associated documentation must be obtained and incorporated into the credentialing and privileging file and VetPro. The practitioner must be afforded an opportunity to explain in writing, the circumstances leading to the agreement. Facility officials must evaluate the primary source information and the individual's explanation of the specific circumstances, documenting this review in the credentialing and privileging file and VetPro.

NOTE: It may be necessary to obtain a signed VA Form 10-0459, Credentialing Release of Information Authorization request from the practitioner, requesting the State licensing board to disclose to VA all malpractice judgments and disciplinary actions as well as all open investigations and outstanding allegations and investigations. Failure by the practitioner to sign VA Form 10-0459 may be grounds for disciplinary action or decision not to appoint.

(4) There may be instances where actions have been taken against an applicant's license for a clinically-diagnosed illness. Those applicants are eligible for appointment where they are acknowledged by the licensing, registering, or certifying entity as stable, the licensure action did not involve substandard care, professional misconduct, or professional incompetence, and the license, certificate, or registration is fully restored. A thorough analysis of the information obtained from the entity must be documented, signed by the appropriate reviewers and approving officials, and filed in the licensure section of the Credentialing and Privileging Folder.

NOTE: Questions concerning applicants who may qualify for appointment under the Rehabilitation Act of 1974, need to be referred to Regional Counsel.

(5) **Exceptions to Licensure.** As part of the credentialing process, the status of an applicant's licensure and that of any required or claimed certifications must be reviewed and primary source verified. Except as provided in VA Handbook 5005, Part II, Chapter 3, subparagraph 14b, all LIPs must have a full, active, current, and unrestricted license to practice in any State, Territory, or Commonwealth of the United States, or in the District of Columbia. The only exceptions provided in VA Handbook 5005 are:

(a) An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a State license

which is limited on the basis of non-citizenship or not meeting the residence requirements of the State.

(b) An individual who has been granted an institutional license by the State which permits faculty appointment and full, unrestricted clinical practice at a specified educational institution and its affiliates, including the VA health care facility; or, an institutional license which permits full, unrestricted clinical practice at the VA health care facility. This exception is only used to appoint an individual who is a well-qualified, recognized expert in the individual's field, such as a visiting scholar, clinician, and/or research scientist, and only under authority of 38 U.S.C. 7405. It may not be used to appoint an individual whose institutional license is based on action taken by a SLB.

(c) An individual who has met all the professional requirements for admission to the State licensure examination and has passed the examination, but who has been issued a time-limited or temporary State license or permit pending a meeting of the SLB to give final approval to the candidate's request for licensure. The license must be active, current, and permit a full, unrestricted practice. Appointments of health care professionals with such licenses must be made under the authority of 38 U.S.C. 7405 and are time-limited, not to exceed the expiration date of licensure.

(d) A resident who holds a license which geographically limits the area in which practice is permitted or which limits a resident to practice only in specific health care facilities, but which authorizes the individual to independently exercise all the professional and therapeutic prerogatives of the occupation. In some States, such a license may be issued to residents in order to permit them to engage in outside professional employment during the period of residency training. The exception does not permit the employment of a resident who holds a license which is issued solely to allow the individual to participate in residency training.

***NOTE:** There may be changes in State licensure requirements and administrative delay by SLBs in processing renewal applications for licensure. For information on these items see VA Handbook 5005, Part II, Chapter 3, Section A, subparagraphs 13f and 13g.*

(6) SLBs may restrict the license of a practitioner for a variety of reasons. Among other restrictions, an SLB may suspend the licensee's ability to independently prescribe controlled substances or other drugs; selectively limit one's authority to prescribe a particular type or schedule of drugs; or accept one's offer or voluntary agreement to limit the authority to prescribe, or provide an "inactive" category of licensure. ***NOTE:** In such cases, the license must be considered restricted for VA purposes, regardless of the official SLB status.*

(7) Some states authorize a grace period after the licensure and/or registration expiration date, during which an individual is considered to be fully licensed and/or registered whether or not the individual has applied for renewal on a timely basis. Facility officials will not initiate separation procedures for failure to maintain licensure or registration on a practitioner whose only license and/or registration has expired if the State has such a grace period and considers the practitioner to be fully and currently licensed and/or registered.

(8) **Physician Applicants.** Physician applicants including physician residents who function outside of the scope of their training program, i.e., who are appointed as Admitting Officer of the Day, must be screened with the FSMB prior to appointment.

(a) The FSMB is a disciplinary information service and reports only those disciplinary actions resulting from formal actions taken by reporting medical licensing and disciplinary boards or similar official sources.

(b) The Screening with the FSMB must be performed through VetPro. Once education has been verified in VetPro, the query can be electronically submitted. Responses are received by VetPro and displayed on the License screen. **NOTE:** *See Appendix C for information on determining which medical staff appointments require an FSMB query.*

(c) Screening applicants with the FSMB does not abrogate the medical facility's responsibility for verifying current and previously held medical licenses with the SLB(s) with the exception of subparagraphs 5o, 6e, and 6f.

(d) Appointment to the medical staff, and granting of clinical privileges is not complete until screening against the FSMB Disciplinary Files is documented in VetPro. It must be documented in VetPro that information obtained through screening against the FSMB Disciplinary Files is verified through the primary source and that this information has been considered during the appointment process. If additional information is needed from the practitioner in response to this information, that must be obtained through, and documented in VetPro.

(e) Those practitioners who were screened against the FSMB Disciplinary Files by VA Central Office in 2002, or subsequent to this date were screened through VetPro, are placed in VHA's FSMB Disciplinary Alerts Service. Practitioners entered into the VHA's FSMB Disciplinary Alerts Service are continuously monitored. Orders reported to the FSMB from licensing entities, as well as the Department of Health and Human Services (DHHS) OIG and the Department of Defense (DOD), initiate an electronic alert that an action has been reported to VHA's Credentialing and Privileging Program Director.

1. The registration of practitioners into this system is based on these queries and only on these queries.

2. This monitoring is on-going for registered practitioners.

3. Alerts received by VHA's Credentialing and Privileging Program Director must be forwarded to the appropriate VA facility for primary source verification and appropriate action. The disciplinary information that pertains to the practitioner can then be downloaded and forwarded to the appropriate facility for review and inclusion in the practitioner's credentials file.

4. Facility credentialing staff must obtain primary source information from the State licensing board for all actions related to the disciplinary alert. Complete documentation of this action, including the practitioner's statement, is to be scanned into VetPro before filing in the paper credentials file. Medical staff leadership is to review all documentation to determine the

impact on the practitioner's continued ability to practice within the scope of privileges granted. This review must be completed within 30 days of the notice to the facility staff of the alert and completely documented in VetPro prior to filing in the paper file.

5. Practitioner names must be removed from the VHA FSMB Disciplinary Alerts Service when the practitioner file is inactivated in VetPro, or when the practitioner's appointment lapses in VetPro.

(9) Appointment of Candidates with Previous or Current Adverse Action Involving Licensure. Physicians and dentists, or other licensed practitioners who have had a license or licenses restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, may be appointed under the appointment procedures that apply to other physicians, dentists, or other health professionals.

(a) Officials included in the appointment process are to thoroughly review and document the review of all SLB documentation (findings of fact detailing the basis for the action against the applicant's license, stipulation agreements, consent orders, and final orders), as well as the applicant's subsequent professional conduct and behavior before determining whether the applicant can successfully serve as a physician, dentist, or other health care practitioner in VA.

(b) To be eligible for appointment, an applicant or employee must meet current legal requirements for licensure (see 38 U.S.C. §§ 7402(b) and (f), and preceding subparagraphs 5g(1) and 5g(2)).

(c) If action was taken against the applicant's sole license, or against all the applicant's licenses, a review by the Chief, Human Resources Management Service, or the Regional Counsel, is necessary to determine whether the applicant meets VA's licensure requirements. Documentation of this review must include the reason for the review, the rationale for conclusions reached, and the recommended action; all this must be filed in the Credentialing and Privileging folder and the appropriate section of VetPro.

(d) Subject to the restrictions in preceding subparagraph 5g(2), those health care professionals who have a current, full and unrestricted license in one or more States, but who currently have or have ever had a license, registration, or certification restricted, suspended, limited, issued and/or placed on probational status, or denied upon application, must not be appointed without a thorough documented review. The credentials file must be reviewed with Regional Counsel, or designee, to determine if the practitioner meets appointment requirements. Documentation of this review must include the reasons for the review, the rationale for the conclusions reached, and the recommended action. The review and the rationale for the conclusions must be forwarded to the VISN Clinical Manager for concurrence and approval of the appointment. All associated documentation must be filed in the Credentialing and Privileging folder and the appropriate section of VetPro.

(10) Verification with SLB(s). Verification of the license:

(a) Can be made through a letter or by telephone and documented on a report of contact. Electronic means of verification are also acceptable, as long as the site is maintained by the

primary source and there is no disclaimer regarding authenticity. If verification of licensure is made by telephone or electronic means, a written request for verification must be made within 5 working days accompanied by VA Form 10-0459 signed by the practitioner requesting verification and disclosure of requested information concerning each:

1. Lawsuit, civil action, or other claim brought against the practitioner for malpractice or negligence;

2. Disciplinary action taken or under consideration, including any open or previously concluded investigations; and

3. Or any changes in the status of the license and all supporting documentation related to the information provided.

(b) May be delegated by the facility Director at the request of the COS.

(c) Must be completed in writing within 30 days of appointment and scanned into VetPro prior to being filed in the paper credentials file.

(d) If the State is unwilling to provide primary source verification of licensure or requested information subsequent to written request, the facility must document the State's specifics of the refusal and secure an authenticated copy of the license from the applicant. If the reason for the SLB's refusal is payment of a fee, the facility needs to pay the fee if the review is for initial appointment.

NOTE: Although credentialing is required for PAs, licensure is not required for employment, so verification of licensure is only required if claimed.

(11) **Filing.** Verification of licensure and/or registration must be filed in Section IV of the Credentialing and Privileging folder and in the Licensure portion of VetPro.

h. Drug Enforcement Agency (DEA) Certification

NOTE: Where a practitioner's State of licensure requires individual DEA certification in order to be authorized to prescribe controlled substances, the practitioner may not be granted prescriptive authority for controlled substances without such individual DEA certification. Questions regarding whether the facility's institutional DEA certification with a suffix meets the State's requirement for individual certification are to be directed to Regional Counsel.

(1) **Background.** Physicians, dentists, and certain other professional practitioners may apply for and be granted renewable certification by the Federal and/or State DEA, to prescribe controlled substances as part of their practice. Certification must be verified for individuals who claim on the application form to currently hold or to have previously held DEA certification. Individual certification by DEA is not required for VA practice, since practitioners may use the facility's institutional DEA certificate with a suffix.

NOTE: In order to prescribe controlled substances, contract licensed health care professionals who practice outside VA facilities must possess individual DEA registration in the State of practice. In order to obtain such individual DEA registration in the State of practice, the practitioner needs to be licensed by that State. However, contract licensed health care professionals who are practicing within VA facilities may rely on the facility's institutional DEA certification with a suffix.

(2) **Application.** Each applicant possessing a DEA certificate must document information about the current or most recent DEA certificate on the appropriate VA application form. Any applicant whose DEA certification (Federal and/or State) has ever been revoked, suspended, limited, restricted in any way, or voluntarily or involuntarily relinquished, or not renewed, is required to furnish a written explanation at the time of filing the application and at the time of reappraisal.

(3) **Restricted Certificates.** A State agency may obtain a voluntary agreement from an individual not to apply for renewal of certification, or may decide to disapprove the individual's application for renewal as a part of the disciplinary action taken in connection with the individual's professional practice. While there are a number of reasons a license may be restricted which are unrelated to DEA certification, an individual's State license is considered restricted or impaired for purposes of VA practice if a SLB has:

- (a) Suspended the person's authority to prescribe controlled substances or other drugs;
- (b) Selectively limited the individual's authority to prescribe a particular type or schedule of drugs; or
- (c) Accepted an individual's offer for voluntary agreement to limit authority to prescribe.

(4) **DEA Verification**

(a) A copy of the current Federal DEA certification must be physically seen prior to appointment and reappointment. Automatic verification of Federal DEA certification can be performed in VetPro when a match can be made against the current Federal DEA certification information maintained in VetPro and electronically updated monthly. If verification can not be made electronically, an authenticated copy of the DEA certificate must be entered into VetPro and filed in Section IV of the standard credentialing and privileging folder.

(b) Verification of a State DEA or Controlled Dangerous Substance (CDS) certificate can be made through a letter or by telephone and documented on a report of contact. Electronic means of verification are also acceptable as long as the site is maintained by the primary source and there is a disclaimer regarding authenticity. If the State is unwilling to provide primary source verification, the facility must document the State's refusal and secure an authenticated copy of the license from the applicant. If the reason for the State's refusal is payment of a fee, the facility needs to pay the fee if the review is at the time of initial appointment or reappointment. This documentation must be filed in Section IV of the standard Credentialing and Privileging folder and in the State CDS section of VetPro.

NOTE: For new appointments after a break in service, any Federal or State DEA certification active at the time of separation must be verified, and any change in status documented.

i. **Employment Histories and Pre-employment References.** For practitioners requesting clinical privileges, at least three references must be obtained, including at least one from the current or most recent employer(s) or institution(s) where the applicant holds or held privileges.

(1) For any candidate whose most recent employment has been private practice for whom employment histories may be difficult to obtain, VA facility officials must contact any institution(s) where clinical privileges are and/or were held, professional organizations, references listed on the application form, and/or other agencies, institutions, or persons who would have reason to know the individual's professional qualifications.

(2) VA Form Letter 10-341a, Appraisal of Applicant, the reference letter printed from VetPro, or any other acceptable reference letter may be used to obtain references. Additional information may be required to fully evaluate the educational background and/or prior experiences of an applicant. Initial and/or follow-up telephone or personal contact with those individuals having knowledge of an applicant's qualifications and suitability are encouraged as a means of obtaining a complete understanding of the composite employment record.

(a) All references must be documented in writing. Written records of telephone or personal contacts must include who was spoken to, that person's position and title, the date of the contact, a summary of the specific information provided, the name of the organization (if appropriate), and the reason why a telephone or personal contact was made in lieu of a written communication. Reports of contact are to be filed with other references in the Official Personnel Folder or, for Title 38 employees who have personnel folders, in the Merged Records Personnel Folder (MRPF) and in the Credentialing and Privileging folder, including VetPro.

(b) For applicants requesting clinical privileges, the facility needs to send a minimum of two requests to verify that the practitioner's currently held or most recently held clinical privileges are (or were) in good standing with no adverse actions or reductions for the specified period. For those health care professionals who have recently completed a training program, one reference needs to be from the Program Director attesting to the individual's competency and skill.

NOTE: Although there is no specific requirement for how many years of personal history is required, work experience, and previous employment is to be verified, the facility is to make a reasonable attempt to verify all experience that is relevant to the privileges being requested. In many instances this could be many years ago if the practitioner has been in practice for a long period of time.

(3) Ideally, references need to be from authoritative sources, which may require that facility officials obtain information from sources other than the references listed by the applicant. As appropriate to the occupation for which the applicant is being considered, references need to contain specific information about the individual's scope of practice and level of performance. For example, information on:

(a) The number and types of procedures performed, range of cases managed, appropriateness of care offered, outcomes of care provided, etc.

(b) The applicant's medical and clinical knowledge, interpersonal skills, communication, clinical judgment, technical skills, and professionalism as reflected in results of quality improvement activities, peer review, and/or references, as appropriate.

(c) The applicant's health status in relation to proposed duties of the position and, if applicable, to clinical privileges being requested.

(4) Employment information and references are filed in Section V of the Credentialing and Privileging folder and the appropriate portion of VetPro.

j. **Health Status.** All applicants and employees, regardless of type of appointment, must have a new appointment after a break in service. They are required to declare on the appropriate health status form that there are no physical or mental health conditions that would adversely affect one's ability to carry out requested responsibilities. This requirement also applies to all who are required to be credentialed in accordance with this policy.

(1) This declaration of health must be confirmed by a physician designated by, or acceptable to, the facility, such as the employee health physician or physician supervisor from the individual's previous employment. Confirmation, at a minimum, is to be in the form of a countersignature by the confirming physician. The confirming physician may not be related to the applicant by blood or marriage.

NOTE: Additional information may be sought from appropriate source(s), if warranted.

(2) All references must be queried as to the applicant's physical and mental capability to fulfill the requirement of the clinical privileges being sought.

(3) The documentation of health and relevant supporting information must be filed in Section V of the Credentialing and Privileging folder and the Personal Profile Screen of VetPro.

k. **Malpractice Considerations**

(1) **Applicants.** VA application forms, or supplemental forms, require applicants to give detailed written explanations of any involvement in administrative, professional, or judicial proceedings, including Federal tort claims proceedings, in which malpractice is, or was, alleged. If an applicant has been involved in such proceedings, a full evaluation of the circumstances must be made by officials participating in the credentialing, selection, and approval processes prior to making any recommendation or decision on the candidate's suitability for VA appointment.

(2) **Employees and Other Returning Practitioners.** At the time of initial hire, a new appointment after a break in service, or reappraisal, each employee or returning practitioner (e.g., contractor) is asked to list any involvement in administrative, professional, or judicial proceedings, including Tort claims, and to provide a written explanation of the circumstances, or change in status. A review of clinical privileges, as appropriate, must be initiated if clinical competence issues are involved. The information provided by the individual must be filed in Section VI of the Credentialing and Privileging folder and in the Supplemental Section of the VetPro file.

(3) **Primary Source Information.** Efforts should be made to obtain primary source information regarding the issues involved and the facts of the cases. The Credentialing and Privileging folder must contain an explanatory statement by the practitioner and evidence that the facility evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication by an insurance company, court of jurisdiction, or statement of claim status from the attorney. A good faith effort to obtain this information must be documented by a copy of the refusal letter or report of contact.

(4) **Evaluation of Circumstances.** Facility evaluating officials must consider VA's obligation as a health care provider to exercise reasonable care in determining that health care professionals are properly qualified, recognizing that many allegations of malpractice are proven groundless.

(a) Facility officials must evaluate the individual's explanation of specific circumstances in conjunction with the primary source information related to the payment in each case. The practitioner's explanatory statement is to be documented in the Supplemental Questions. A practitioner's statement included in the NPDB-HIPDB report does not satisfy the need for the practitioner to provide an explanation.

(b) This review must be documented and filed in Section VI of the standard folder and the appropriate section in VetPro. Reasonable efforts must be made to ensure that only health care professionals who are well-qualified to provide patient care are permitted to do so.

(c) NPDB-HIPDB reports contain information regarding any malpractice payment made on behalf of the practitioner. This information is considered a secondary source and does not meet the standard of primary source verification. Primary source verification must be obtained on this information from the appropriate sources.

***NOTE:** Questions concerning legal aspects of a particular case need to be directed to the Regional Counsel or General Counsel.*

1. NPDB – HIPDB Screening

(1) Proper screening through the NPDB-HIPDB is required for applicants, including: physician residents who function outside of the scope of their training program, i.e., those

appointed as Admitting Officer of the Day; all members of the medical staff and other health care professionals who hold clinical privileges, who are, or have ever been, licensed to practice their profession or occupation in any job title represented in the NPDB and HIPDB Guidebooks; or who are required to be credentialed in accordance with this policy. The NPDB-HIPDB is a secondary flagging system intended to facilitate a comprehensive review of health care practitioners' professional credentials. The information contained in the NPDB-HIPDB is intended to direct discrete inquiry into, and scrutiny of, specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history, Federal health care program exclusion status, and record of clinical privileges. The information received in response to an NPDB-HIPDB query is to be considered together with other relevant data in evaluating a practitioner's credentials; it is intended to augment, not replace, traditional forms of credentials review. NPDB-HIPDB screening is required prior to appointment, including reappointment and transfer from another VA facility, whether or not VA requires licensure for appointment, reappointment, or transfer. This screening must be accomplished by enrolling the practitioner in the NPDB-HIPDB PDS. The NPDB-HIPDB PDS provides on-going monitoring of health care practitioners.

***NOTE:** All practitioners must be enrolled in the NPDB-HIPDB PDS within 30 days of the availability to do so through VetPro regardless of their current appointment status. Guidance on the enrollment process distributed separately.*

(a) After initial enrollment, each facility is required to renew the enrollment for each practitioner in the NPDB-HIPDB PDS on, or before, the expiration of the annual enrollment; and

(b) To confirm enrollment of practitioners in the NPDB-HIPDB PDS system through review of practitioner names from VetPro against NPDB-HIPDB PDS.

***NOTE:** If currently detailed to another VA facility or serving another facility as a consultant, the receiving facility must enroll the practitioner in the NPDB-HIPDB PDS, in addition to the main facility.*

(2) These procedures apply to all the VHA physicians, dentists, and other health care practitioners who are appointed to the medical staff or who hold clinical privileges whether utilized on a full-time, part-time, intermittent, consultant, attending, WOC, on-station fee-basis, on-station scarce medical specialty contract, or on-station sharing agreement basis.

***NOTE:** The requirements to enroll and monitor practitioners through the NPDB-HIPDB PDS does not apply to trainees other than those who function as staff outside the scope of their training program; i.e., residents who serve as Admitting Officers of the Day.*

(3) VetPro maintains evidence of query submission and response received, as well as any reports obtained in response to the query, and it meets the NPDB-HIPDB requirement.

(4) Because the NPDB-HIPDB is a secondary information source, any reported information must be validated by appropriate VA officials with the primary source, i.e., SLB, health care

entity, malpractice payer to include, but not limited to the circumstances for payment (e.g., payment history in and of itself is not sufficient).

(5) Screening applicants and appointees with the NPDB-HIPDB and enrollment in the NPDB-HIPDB PDS does not abrogate the COS's and appropriate service chief's responsibility for verifying all information prior to appointment, privileging and/or re-privileging, or proposed Human Resource Management action.

NOTE: All queries to the NPDB from a VA facility automatically query the HIPDB.

(6) If the NPDB-HIPDB screen shows adverse action or malpractice reports, an evaluation of the circumstances and documentation thereof, is required. This evaluation needs to follow the guidelines outlined in preceding subparagraph 5k(4) entitled "Evaluation of Circumstances," for malpractice, and similarly for adverse actions. *NOTE: This requirement does not apply to individuals functioning within the scope of a training program.*

(7) The facility Director is the authorized representative who authorizes all submissions to the NPDB-HIPDB. Any delegation of that authority to other facility officials is to be documented, in writing, to include date of delegation, circumstances governing delegation, and title (not name) of the official who may make requests.

(8) NPDB-HIPDB screening information is filed in Section VI of the Credentialing and Privileging folder and the appropriate section of VetPro.

m. Appointment and Termination of Employment under Title 5 and Title 38 Staff Relative to NPDB-HIPDB Screening

(1) Clinically privileged and otherwise credentialed practitioners affected by this Handbook are to be appointed only after enrollment in the NPDB-HIPDB PDS has been initiated, including Temporary Appointment for Urgent Patient Care Needs (see subpar. 5p) and Expedited Appointments

(2) If the NPDB-HIPDB screen through enrollment in the NPDB-HIPDB PDS shows action against clinical privileges, adverse action regarding professional society membership, medical malpractice payment for the benefit of the practitioner, or Federal health care program exclusion, facility officials must verify that the practitioner fully disclosed all related information required and requested by VA in its pre-employment, credentialing, and/or clinical privileging procedures.

(3) The practitioner may be employed or continued in employment only after applicable procedural requirements are met.

(4) Any notification from the NPDB-HIPDB PDS must be reported to the Director, Credentialing and Privileging, or designee, within 2 workdays of receipt of the report. This includes reports received on initial enrollment in the service, and all subsequent reports received.

(5) Following are the types of reports that a facility might receive and the action, or source of guidance for action, to be used in each case.

NOTE: The NPDB-HIPDB reports are maintained electronically in VetPro.

(a) If an NPDB-HIPDB report indicates any multiple of the following actions, requirements for each must be met.

1. Evidence of Disciplinary Action by any SLB. Documentation of thorough review by officials involved in the appointment process of information obtained from the primary source SLB taking the disciplinary action.

2. Adverse Action Taken Against Clinical Privileges. A reference from the facility(ies) or health care organization that took the action against the clinical privileges, detailing the privileges held and reason for adverse action, must be included with the credentialing information. Documentation of a thorough review by officials involved in the appointment process must be included.

3. Adverse Action Regarding Professional Society Membership. Particulars of the action must be verified with the professional society and documentation of the thorough review by officials involved in the appointment process included with credentialing information.

4. Medical Malpractice Payment for the Benefit of the Practitioner. Facility officials must evaluate the primary source information (e.g., information obtained from the insurance company or court records, etc.) and the individual's explanation of specific circumstances in each case. They may require the practitioner to provide copies of documents pertaining to the case. Questions regarding legal aspects of a particular case are to be directed to Regional Counsel. Documentation of all efforts in this regard must be a part of the credentialing information.

(b) Reviews conducted subsequent to NPDB-HIPDB reports are to be thoroughly documented in the credentialing and privileging record (electronic and paper). Reviews include, but are not limited to, the Service Chief's as well as the preliminary review of the Executive Committee of the Medical Staff and could result in a decision to recommend:

1. Appointment, or continue in an appointed status with no change in originally anticipated action.

2. Appointment, or continue appointment status with changes, including, but not limited to, modification of clinical privileges or provision of training.

3. Non-appointment or termination.

(c) In order to ensure an appropriate review is completed in the credentialing process, a higher-level review must be performed by the VISN CMO to ensure 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 review must be completed prior to presentation to the Executive Committee of the Medical Staff, for review and recommendation to continue the appointment and privileging process.

1. Circumstances requiring review by the VISN CMO are:
 - a. Three or more medical malpractice payments in payment history,
 - b. A single medical malpractice payment of \$550,000 or more, or
 - c. Two medical malpractice payments totaling \$1,000,000 or more

NOTE: *This second level review is in no way an indication that practitioners who meet these criteria are more likely to have clinical practice issues.*

2. The VISN CMO, in this oversight role, may request additional information as to the specific circumstance of the report or the facility's review process. The VISN CMO review must be documented on the Service Chief's Approval screen in VetPro as an additional entry recommending appointment in these cases.

NOTE: *Files previously reviewed with no change in information do not need to be submitted for VISN CMO review. If there is any change in information at the time of reappraisal, including those files which meet the preceding criteria but not previously reviewed by the VISN CMO on or before October 10, 2007, must be referred to the VISN CMO for review.*

(d) Once requirements for consideration and evaluation of any action reported by NPDB-HIPDB have been completed, the appointment or continued appointment decision, if appropriate, must be made following guidance in this Handbook; Title 5 policies and procedures specified in Title 5 Code of Federal Regulations (CFR) 315, 731, or 752; Federal or VA acquisition regulations; VA Directive and Handbook 0710; and VA Directive and Handbook 5021, as they apply to the category of practitioner.

(e) When any initial or subsequent NPDB-HIPDB report calls into question the professional competence or conduct of an individual appointed by VA, the facts and circumstances are to be reviewed to determine what action would be appropriate, including such actions as revision of clinical privileges, removal, etc. Such actions must be closely coordinated with the Human Resource Management Service (and in the case of contracts and sharing agreements with Acquisition and Materiel Management Service) to ensure that they are processed in accordance with applicable requirements.

(6) The Director, Credentialing and Privileging, or designee, must monitor the fact that a report was received by the facility until the review of the circumstances and any necessary action by facility staff is documented in VetPro. Facility staff must provide updates every 30 days until all information is collected and any necessary action documented; however, closure is expected within 90 days of receipt of the report.

n. **Credentialing for Telehealth and Teleconsultation.** When the staff of a facility determines that telemedicine and/or teleconsultation is in the best interest of quality patient care, appropriate credentialing and privileging is required.

(1) The facility Director(s) must ensure appropriate mechanisms are in place for verifying and undertaking privileging of off-site providers who deliver services using telemedicine or teleconsultation both at the site providing telemedicine or teleconsultation and the site receiving these services, in order to insure that the care delivered fits within the resources of the facility(ies) and scope of practice of the practitioners.

(a) All practitioners treating patients using telemedicine and teleconsultation must be qualified to deliver the required level of consultation, care, and treatment with the appropriate credentialing and privileging, regardless of the technology used, and they must be credentialed and privileged to deliver that care. This ensures that mechanisms are provided for appropriate appointment, credentialing, and privileging of providers both at the site providing the telemedicine and/or teleconsultation and at the site receiving these services, in order to ensure the care delivered fits within the resources of the facility and scope of practice of the practitioners.

(b) The practitioner providing the telemedicine and/or teleconsultation services must be credentialed and privileged in accordance with this Handbook.

(2) **Teleconsultation.** The practitioner providing only teleconsultation services must be appointed, credentialed, and privileged at the site at which the practitioner is physically located when providing teleconsultation services.

(a) These practitioner's credentials must be shared with the facility receiving the teleconsultation services using shared access of the VetPro file.

(b) With the exception of the separate NPDB-HIPDB query discussed in subparagraph 5n(3), the practitioner providing teleconsultation services does not have to be separately appointed or credentialed at the facility or site where the patient is physically located.

(c) When the practitioner provides only teleconsultation by offering advice that supports care provided by the on-site licensed independent privileged provider, a copy of the practitioner's current clinical privileges must be made available to the facility or site where the patient is physically located. The practitioner providing teleconsultation services does not have to be separately privileged at the facility or site where the patient is physically located.

(3) **Telemedicine.** When telemedicine services are being provided by the practitioner who directs, diagnoses, or otherwise provides clinical treatment (i.e., teleradiology, teledermatology, etc.) to a patient using a telemedicine link, the practitioner must be appointed, credentialed, and privileged at the facility which receives the telemedicine services (patient site), as well as at the site providing the services.

(a) A separate delineation and granting of privileges must be made by the facility receiving the telemedicine services. Appropriate credentialing needs to be performed by the facility

receiving the telemedicine services prior to the granting of these privileges, including response to the Supplemental Questions, licensure verification, confirmation of current competency, and a NPDB-HIPDB query.

***NOTE:** Telemedicine involves the use of technology and is therefore a modality for the delivery of existing clinical practices. As such, there are no separate or distinct privileges for telemedicine. When considering the granting of privileges at the facility where the practitioner is physically based, the general privileging process needs to include the appropriateness of using telemedicine to deliver services and this site is considered a separate site of care in the establishment of privileges. Any consideration concerning the appropriate utilization of telemedicine equipment by the practitioner needs to be considered as part of the privileging process by the facility where the practitioner is physically located.*

(b) Before a remote practitioner conducts either telemedicine and/or teleconsultation with another facility or site, the facility or site where the patient is physically located must enroll the practitioner in the NPDB-HIPDB PDS. The NPDB-HIPDB PDS registration must be renewed in accordance with credentialing and reappraisal requirements of this policy. ***NOTE:** If this is not done, it must be clearly documented why an NPDB-HIPDB query was not completed before the practitioner engages in patient care using telemedicine and/or teleconsultation.*

(4) **Contracts for Telemedicine and/or Teleconsultation Services.** Contracts for telemedicine and/or teleconsultation services need to require that these services be performed by appropriately-licensed individuals. Unless otherwise required by the specific contract or Federal law (such as the Federal Controlled Substances Act), contract health care professionals must meet the same licensure requirements imposed on VA employees in the same profession whether they are on VA (Federal) property or not when providing telemedicine or teleconsultation services.

***NOTE:** Some states do not allow telemedicine and/or teleconsultation across state lines, unless the provider is licensed in the state where the patient is physically located. In these states, the clinical indemnity coverage of contract practitioners may be void, even if they are credentialed and privileged by VA. Prior to the commencement of services by the contract practitioners providing telemedicine and/or teleconsultation or remotely monitoring physiology data from veteran patients, the State regulatory agency in the state in which the practitioner is physically located as well as the state where the patient is physically located, must be consulted. When dealing with Federal entities, additional licenses that authorize the provision of telemedicine and/or teleconsultation services in the relevant states may not be required. The opinion of the Regional Counsel needs to be sought in these matters.*

o. **Expedited Appointment to the Medical Staff.** There may be instances where expediting a medical staff appointment for LIPs is in the best interest of quality patient care. This process may be incorporated into the appropriate VHA medical treatment facility Bylaws, policy, or procedures for expediting the medical staff appointment.

(1) The credentialing process for the Expedited Appointment to the Medical Staff cannot begin until the LIP completes the credentials package, including but not limited to a complete

application; therefore, the provider must submit this information through VetPro and documentation of credentials must be retained in VetPro.

(2) Credentialing requirements for this process must include confirmation of:

a. The physician's education and training (which, if necessary, can be accomplished in 24 hours through the purchase of the American Medical Association's Physician Profile);

b. One active, current, unrestricted license verified by the primary source State, Territory, or Commonwealth of the United States or in the District of Columbia;

NOTE: To be eligible for appointment, a practitioner must meet current legal requirements for licensure (see 38 U.S.C. § 7402(b) and (f), and preceding subpar. 5g).

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

d. Query of licensure history through the FSMB Action Data Center with no report documented;

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

f. Current comparable privileges held in another institution; and

g. NPDB-HIPDB PDS registration with documentation of no match.

(3) If all credentialing elements are reviewed and no current or previously successful challenges to any of the credentials are noted; and there is no history of malpractice payment, a delegated subcommittee of the Executive Committee of the Medical Staff, consisting of at least two members of the full committee, may recommend appointment to the medical staff. Full credentialing must be completed within 60 calendar days and presented to the Executive Committee of the Medical Staff for ratification.

(4) The expedited appointment process may only be used for what are considered "clean" applications. The expedited appointment process can not be used:

(a) If the application is not complete (including answers to Supplemental Questions, Declaration of Health, and Bylaws Attestation); or

(b) If there are current or previously successful challenges to licensure; or

(c) If there is any history of involuntary termination of medical staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges; or

(d) If there has been a final judgment adverse to the applicant in a professional liability action.

(5) This recommendation by the delegated subcommittee of the Executive Committee of the Medical Staff must be acted upon by the VHA medical treatment facility Director. The 60 calendar days for the completion of the full credentialing process begins with the date of the Director's signature.

(6) This process does not relieve the local VHA medical treatment facilities from reviewing the DHHS, OIG's List of Excluded Individuals and Entities (LEIE) for information on whether a provider is excluded from receiving or directing the expenditure of Federal health care program funds for items or services the provider provides, orders, or prescribes while excluded.

(7) Expedited appointment to the medical staff process does not relieve VHA medical treatment facilities from any appointment requirements as defined by the Human Resources Management Program and acquisition requirements.

(8) For those providers where there is evidence of a current or previously successful challenge to any credential or any current or previous administrative or judicial action, the expedited process cannot be used and complete credentialing must be accomplished for consideration by the Executive Committee of the Medical Staff.

(9) This is a one-time appointment process for initial appointment to the medical staff and may not exceed 60 calendar days. It may not be extended or renewed. The complete appointment process must be completed within 60 calendar days of the Expedited Appointment or the medical staff appointment is automatically terminated. The effective date of appointment is the date that the expedited appointment is signed by the Director, even though ratification of the appointment is accomplished within 60 calendar days (the effective date does not change).

p. **Temporary Medical Staff Appointments for Urgent Patient Care Needs.** *NOTE: Temporary appointments are for emergent or urgent patient care only and NOT to be used for administrative convenience.*

(1) Temporary medical staff appointments for urgent patient care needs may require appointment before full credentialing information has been received. Since credentialing is a key component in any patient safety program, the appointment of providers with less than complete credentials packages warrants serious consideration and thorough review of the available information. Examples include:

(a) A situation where a physician becomes ill or takes a leave of absence and a LIP would need to cover the physician's practice until the physician returns.

(b) A situation where a specific LIP with specific skill is needed to augment the care to a patient that the patient's current privileged LIP does not possess.

(2) The facility must use defined criteria for those instances, which may include the preceding examples, in which Temporary Appointments for Urgent Patient Care Needs are appropriate. Criteria must include the circumstances under which they will be used and the applicant criteria.

NOTE: It is not always possible to predict in advance what comprises an urgent patient care need or when it will occur, but facilities need to have predefined criteria that would require the use of Temporary Medical Staff Appointments for Urgent Patient Care Needs.

(3) When there is an emergent or urgent patient care need, a temporary appointment may be made, in accordance with VA Handbook 5005, Part II, by the facility Director prior to receipt of references or verification of other information and action by a Professional Standards Board. Minimum required evidence includes:

- (a) Verification of at least one, active, current, unrestricted license with no previous or pending actions;
- (b) Confirmation of current comparable clinical privileges;
- (c) Response from NPDB-HIPDB PDS registration with no match;
- (d) Response from FSMB with no reports;
- (e) Receipt of at least one peer reference who is knowledgeable of and confirms the provider's competence, and who has reason to know the individual's professional qualifications; and
- (f) Documentation by the facility Director of the specific patient care situation that warranted such an appointment.

NOTE: In those cases where an application is completed prior to the Temporary Appointment for Urgent Patient Care needs, it must be a "clean" application with no current or previously successful challenges to licensure; no history of involuntary termination of medical staff membership at another organization; no voluntary limitation, reduction, denial, or loss of clinical privileges; and no final judgment adverse to the applicant in a professional liability action.

(4) Temporary appointments must be completed in VetPro including the NPDB-HIPDB PDS registration and response, and the FSMB query and response. These appointments may not be renewed or repeated.

(5) An application through VetPro must be completed within 3 calendar days of the date the appointment is effective. This includes Supplemental Questions, a Declaration of Health, and a

Release of Information. This additional information facilitates the required completion of the practitioner credentialing for these practitioners used in urgent patient care needs situations, as well as providing additional information for evaluation of the current Temporary Appointment and reducing any potential risk to patients.

(6) If the Temporary appointment is not converted to another form of medical staff appointment, complete credentialing must be completed, even if completion occurs after the practitioner's temporary appointment is terminated or expires. At a minimum, the LIP must submit a VetPro application, and all credentials must be verified. If unfavorable information was discovered during the course of the credentialing, a review of the care provided may be warranted to ensure that patient care standards have been met.

NOTE: Temporary appointments for urgent patient care needs may not exceed the length of time of the Temporary appointments (see subpar. 6e).

q. **Reappraisal.** Reappraisal is the process of evaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the facility. The reappraisal process must include: the practitioner's statements regarding successful or pending challenges to any licensure or registration; voluntary or involuntary relinquishment of licensure or registration; limitation, reduction or loss of privileges at another hospital; loss of medical staff membership; pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment; mental and physical status; and any other reasonable indicators of continuing qualification and competency. Additional information regarding current and/or changes in licensure and/or registration status (primary source verification is required at the time of expiration of the license and at the time of reappointment); NPDB-HIPDB PDS registration and report results; peer recommendations; continuing medical education and continuing education units; and verification regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review. *NOTE: Information from VA Form 10-2623, Proficiency Report, or VA Form 3482b, Performance Appraisal, may be used.*

(1) Health care professionals with multiple licenses, registrations, and/or certifications are responsible for maintaining these credentials in good standing and informing the Director, or designee of any changes in the status of these credentials at the earliest date after notification is received by the individual. At the time of expiration of any license, and at the time of reappraisal, prior to reappointment, the practitioner must provide a signed release of information VA Form 10-0459 which authorizes the primary source to provide VA with written verification of requested information and to disclose information concerning each lawsuit, civil action, or other claim brought against the practitioner for malpractice or negligence; each disciplinary action taken or under consideration; any open or previously concluded investigations; any changes in the status of the license; and all supporting documentation related to the information provided.

NOTE: Facility staff must be cognizant of the time it takes to complete the written verification of licensure at the time of expiration and reappraisal. They must ensure that practitioners

submit all necessary information including updated information VA Form 10-0459 in order to complete verification prior to expiration of license or reappointment or practitioner will not be allowed to practice.

(2) If at any time, after the initial appointment, it is noted that a provider has a license revoked for substandard care, professional misconduct, or professional incompetence, immediate consultation with the Regional Counsel is required in order to ensure the practitioner meets current legal requirements for licensure (see 38 U.S.C. §§ 7402(b) and (f) and subpar. 5g).

NOTE: For those practitioners appointed prior to November 30, 1999, for whom it is verified that a license, registration, or certification has been previously revoked for substandard care, professional misconduct, or professional incompetence, a thorough review of the circumstances must be performed and the relevance to professional conduct and clinical practice must be documented in the license portion of the credentialing and privileging folder. Consultation with Regional Counsel is encouraged in order to ensure the practitioner meets current legal requirements for licensure, registration, or certification (see 38 U.S.C. §§ 7402(b) and (f)).

(3) The Director is responsible for establishing a mechanism to ensure that multiple licenses, registrations, and/or certifications are consistently held in good standing or, if allowed to lapse, are relinquished in good standing.

(a) For credentials that were held previously, but are no longer held or are no longer full and unrestricted, the practitioner must be asked to provide a written explanation of the reason(s).

(b) The verifying official must contact the SLB(s) or issuing organization(s) to verify the reason(s) for any change.

r. **Transfer of Credentials.** When practitioners are assigned to more than one health care facility for clinical practice, the “primary” or originating facility must convey all relevant credentials information to the gaining or satellite facility. This may be accomplished by forwarding an authenticated true copy of the Credentialing and Privileging folder to the receiving facility. The VetPro electronic credentials file must be shared with the gaining or satellite facility. A copy of the original employment application, VA Form 10-2850, Application for Physicians, Dentists, Podiatrists, Optometrists and Chiropractors, or other appropriate appointment information needs to be provided to the gaining facility. The authenticated copy is joined with the formal application for clinical privileges and any other facility-specific forms. The gaining facility may use its own customary forms or format for notifying practitioners of their clinical appointments and documenting same. *NOTE: The gaining facility must register the practitioner with the NPDB-HIPDB PDS, obtain primary source verification of all active licenses, accept the transferred credentials, appoint the practitioner, and grant the appropriate clinical privileges before the practitioner can engage in patient care.*

s. **Disposition of Credentialing and Privileging Files**

(1) When a VA practitioner separates from VA practice, the Credentialing and Privileging folder must be maintained by the last facility of appointment and then retired to the VA Records Center 3 years after the practitioner separates from VA practice. **NOTE:** *The Records Officer at each facility is responsible to advise anyone regarding the disposition of records.*

(2) When a VA practitioner transfers from one VA facility to another, the original Credentialing and Privileging folder needs to be transferred to the gaining facility immediately upon transfer. **NOTE:** *This needs to be accomplished by a means that allows for tracking of the file through the transfer process, e.g., overnight mail or certified mail return receipt requested. These folders contain Personally Identifiable Information (PII), therefore, whatever means is used to transmit these folders must be in accordance with VA policy regarding transmission of PII, currently stated in VA Directive 6502.1 and any subsequent revisions.*

(3) Credentialing and Privileging folders on applicants not selected for VA practice are to be destroyed 2 years after non-selection, or when no longer needed for reference, whichever is sooner.

(4) Electronic credentialing files in VetPro must be inactivated through the File Administration Screen at the time of separation or non-selection.

(5) Credentialing folders may be thinned if they become difficult to manage, but the backup material must be available in the facility.

6. PRIVILEGING

NOTE: *Paragraph 6 contains the administrative and clinical requirements and procedures relating to the granting of clinical privileges, reappraisal, and re-privileging, and reduction and revocation of privileges.*

a. Provisions

(1) Privileges must be facility specific. This means that privileges can only be granted within the scope of the medical facility mission. Only privileges for procedures actually provided by the VA facility may be granted to a practitioner.

(2) Only practitioners who are licensed and permitted by law and the facility to practice independently may be granted clinical privileges.

(3) Clinical privileging is the process by which the institution grants the practitioner permission to independently provide specified medical or other patient care services, within the scope of the practitioner's license and/or an individual's clinical competence, as determined by peer references, professional experience, health status (as it relates to the individual's ability to perform the requested clinical privileges), education, training, and licensure and registration.

NOTE: *The delineation of clinical privileges must be: facility specific, setting specific, and provider specific.*

b. **Review of Clinical Privileges.** Applicants completing application forms are required to respond to questions concerning clinical privileges at VA and non-VA facilities. A minimum of two efforts to obtain verification of clinical privileges currently, or most recently, held at other institutions is to be made and documented in writing in the Credentialing and Privileging folder. That verification needs to indicate whether the privileges are (or were) in good standing with no adverse actions or reductions for the specified period of time. If the verification indicates that there are pending, or were previous, adverse actions or reductions for the specified period of time, the particulars of the action or reduction must be obtained and documentation of a thorough review by officials involved in the appointment process must be included with credentialing information.

c. **Procedures.** Privileges are granted according to the procedures delineated within this Handbook, which must be reflected in the Medical Staff Bylaws, Rules, and Regulations. Clinical privileges are granted for a period not to exceed 2 years. Clinical privileges are not to be extended beyond the 2-year period, which begins from the date the privileges are signed, dated, and approved by the facility Director. However, clinical privileges granted to contractors may not extend beyond the contract period. Each new contract period requires reappraisal and re-privileging. The process for the renewal of clinical privileges needs to be initiated no later than 2 to 3 months prior to the date the privileges expire.

***NOTE:** It is the responsibility of the facility and the practitioner to ensure that privileges are reviewed and renewed by the expiration date in order to prevent a lapse in the practitioner's authority to treat patients. Applicants for privileges must be kept apprised of the status of their application and must be involved in clarification of issues, as appropriate.*

(1) **General Criteria.** General criteria for privileging must be uniformly applied to all applicants.

(a) Such criteria must include, at least:

1. Evidence of current licensure;
2. Relevant training and/or experience;
3. Current competence, and health status (as it relates to the individual's ability to perform the requested clinical privileges); and
4. Consideration of any information related to medical malpractice allegations or judgments, loss of medical staff membership, loss and/or reduction of clinical privileges, or challenges to licensure.

(b) Each service chief must establish additional criteria for granting of clinical privileges within the service consistent with the needs of the service and the facility. Clinical privileges must be based on evidence of an individual's current competence. When privilege delineation is based primarily on experience, the individual's credentials record must reflect that experience, and the documentation must include the numbers, types, and outcomes of related cases.

(2) **Delineation of Privileges.** Delineated clinical privileges are an accurate, detailed, and specific description of the scope and content of patient care services for which a practitioner is qualified; they are based on credentials and performance and are authorized by the facility.

(a) The criteria for the delineation of privileges are determined by the individual services, recommended by the Executive Committee of the Medical Staff as defined in the Medical Staff Bylaws, and approved by the facility Director. These criteria for the delineation and granting of privileges are to be reviewed on a regular basis as defined in the Medical Staff Bylaws.

(b) Privileges granted to an applicant must be facility specific and based on the procedures and types of services that are provided within the health care facility. The requirements or standards for granting privileges to perform any given procedure, if performed by more than one service, must be the same. One standard of care must be guaranteed regardless of practitioner, service, or location within the facility.

(c) The VA medical facility must delineate the process for granting privileges by any combination of: level of training and experience; patient risk categories, and lists of procedures or treatments. The process to be used must be established by the individual services and recommended by the Executive Committee of the Medical Staff. The process by which privileges are delineated must be documented as part of local VA facility bylaws. An acceptable model might combine pertinent risk categories with specific clinical areas to produce a list of procedures by specialty and/or service area. At a minimum, consideration needs to be given to evidence of relevant training or experience, current competence, and the ability to perform the privileges. Each clinical service or specialty is responsible to follow the locally-delineated policy in defining the levels or categories of privileges being recommended for approval of the medical staff's Executive Committee.

(3) **Service Specific Privileges.** Each practitioner must be assigned to, and have clinical privileges in, one clinical service and may be granted privileges in other clinical services. For example, a physician may have privileges in neurology and psychiatry, if appropriate. The exercise of clinical privileges within any service is subject to the policies and procedures of that service and the authority of that service chief.

(4) **Setting Specific Privileges.** The settings in which care is delivered dictate the type(s) of care, treatment, and services or procedures that a practitioner will be authorized to perform. Privileges are setting specific, within the context of each facility, requiring consideration of each unique setting's characteristics, such as: adequate facilities, equipment, and number and type of qualified support personnel and resources. Setting-specific privileges are granted based on the practitioner's qualifications, and on consideration of the procedures and types of care, treatment, and services that can be performed or provided within the proposed setting.

***NOTE:** Practitioners who do not have the specified privileges for a specific setting are not to practice in that setting, even if they believe the privileges granted are comparable for that setting.*

d. Initial Privileges. Clinical privileges must be granted for all physicians, dentists, and other health care professionals licensed for independent practice, covered by this Handbook when they are involved in patient care. The intent of this process is to ensure that all physicians, dentists, and other health care practitioners, when they are functioning independently in the provision of medical care, have privileges that define the scope of their actions, which is based on current competence within the scope of the mission of the facility, and other relevant criteria. Documentation of clinical activity (i.e., evidence that a practitioner has performed a procedure) is one component of the competency equation. The second component is whether or not the practitioner has had good outcomes in practice or when performing a procedure. The process for the requesting and granting of clinical privileges follows:

(1) Clinical privilege requests must be initiated by the practitioner. For all practitioners desiring clinical privileges, the initial application for appointment must be accompanied by a separate request for the specific clinical privileges desired by the applicant. The applicant has the responsibility to establish possession of the appropriate qualifications, and the clinical competency to justify the clinical privileges request.

(2) The applicant's request for clinical privileges, as well as all credentials offered to support the requested privileges, must be provided for review to the service chief responsible for that particular specialty area. The service chief must review all credentialing information including health status (as it relates to the ability to perform the requested clinical privileges), experience, training, clinical competence, judgment, clinical and technical skills, professional references, conclusions from performance improvement activities that are not protected under 38 U.S.C 5705 (see **NOTE** following subpar. 6g(1)(a)(2)(c)), and any other appropriate information. The documentation of this review must include, at least, a list of the documents reviewed and the rationale for the conclusions. The service chief must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending individual privileges and personally complete the "Service Chief's Approval" in VetPro. Upon completion of this assessment, the service chief makes a recommendation as to the practitioner's request for clinical privileges. The service chief recommends approval, disapproval, or a modification of the requested clinical privileges. This recommendation may include a limited period of direct supervision, or proctoring, by an appropriately-privileged practitioner for privileges when a practitioner has had a lapse in clinical activity, or for those procedures that are high risk as defined by medical center policy.

NOTE: *The Service Chief Approval must be completed by the service chief and no portion of this process may be delegated, including documentation in VetPro.*

(3) Subsequent to the service chief's review and recommendation, the request for privileges, along with the appointment recommendation of the Professional Standards Board (PSB) or credentialing committee (if applicable), must be submitted to the medical staff's Executive Committee for review. The medical staff's Executive Committee evaluates the applicant's credentials to determine if clinical competence is adequately demonstrated to support the granting of the requested privileges. Minutes must reflect the documents reviewed and the

rationale for the stated conclusion. A final recommendation is then submitted to the facility Director.

(4) Residents who are appointed, outside of their training program, to work on a fee basis as Admitting Officer of the Day must be licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program, and must meet the same requirements as all physicians and dentists appointed at the facility. The term "resident" includes health care professionals in advanced PG education programs who are typically referred to as "fellows."

(5) Copies of current clinical privileges must be available to hospital staff on a need-to-know basis in order to ensure providers are functioning within the scope of their clinical privileges. Operating rooms and intensive care units are examples of areas where staff must be aware of provider privileges. Copies of privileges may be given to individuals on a need-to-know basis (e.g., a service chief responsible for monitoring compliance with the privileges granted, or a pharmacist who verifies prescribing privileges or establishes limitations on prescribing for certain medical staff members). The mechanism is to be concurrent with the exercise of privileges, not retrospective. *NOTE: Practitioners performing procedures outside the scope of their privileges may be subject to disciplinary or administrative action.*

(6) The requesting and granting of clinical privileges for COSs and facility Directors must follow the procedures, as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant service chief responsible for the particular specialty area in which the COS or Director requests privileges. When considering clinical privileges for the COS an appropriate practitioner must chair the medical staff's Executive Committee and the COS must be absent from the deliberations. The medical staff's Executive Committee recommendation regarding approval of requested privileges is submitted directly to the facility Director for action.

(7) The privileging of facility COS and Director desiring clinical privileges must follow the procedures as outlined for new practitioners. The approval authority for the requested privileges is to be delegated to the Associate Director, who is authorized to act as facility Director for this purpose.

(8) In those instances where a VISN CMO or Director, or other staff not directly employed by the facility (e.g., VA Central Office) is requesting clinical privileges, the process for such clinical privileges must follow the procedures, as outlined for other practitioners. The request for privileges must be reviewed, and a recommendation made, by the relevant service chief responsible for the particular specialty area. The medical staff's Executive Committee recommendations regarding approval of requested privileges must be submitted directly to the facility Director for action.

(9) When a privileged practitioner is being considered for transfer, detail, or to serve as a consultant to another VA facility, transfer of credentials are to be accomplished as outlined in subparagraph 5r. Other than teleconsultation, in all cases, the practitioner must request privileges at the gaining facility and provide the facility with the required documentation. Since

privileges are facility specific as well as practitioner specific, they are not transferable. The receiving facility must have the practitioner apply to the facility, complete the reappraisal process, including the verification of all time-limited credentials and a new registration with the NPDB-HIPDB PDS.

(10) A denial of initial privileges, for whatever reason, is not reportable to the NPDB. Where it is determined, for whatever reason, that the initial application and request for clinical privileges should be denied, the credentialing file, and appropriate minutes must document that a medical staff appointment is not being made and no privileges are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the facility Director. A "Do Not Appoint" screen must be completed in VetPro documenting the date of the decision (see subpar. 6h(1)).

e. **Temporary Privileges for Urgent Patient Care Needs.** Temporary privileges for health care professionals in the event of emergent or urgent patient care needs may be granted by the facility Director at the time of a temporary appointment. Such privileges must be based on documentation of a current State license and other reasonable, reliable information concerning training and current competence. The recommendation for temporary privileges must be made by the COS and approved by the facility Director. Temporary privileges are not to exceed 60 calendar days.

f. **Disaster Privileges.** Disaster privileges may be granted when the facility has chosen to incorporate a process for granting disaster privileges into the credentialing and privileging process and emergency management plan, the emergency management plan has been activated, and the facility is unable to handle the immediate patient needs. At a minimum the process for granting disaster privileges must include:

- (1) Identification of the individual(s) responsible for granting disaster privileges.
- (2) A description of the responsibilities of the individual(s) responsible for granting disaster privileges.
- (3) A description of the mechanism to manage the activities of the health care professionals who are granted disaster privileges, as well as a mechanism to readily identify these individuals.
- (4) A description of the verification process at the time disaster privileges are granted which must include:
 - (a) A current hospital photo identification card and evidence of current license to practice;
or
 - (b) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); or
 - (c) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a Federal, state, or municipal entity.

(5) A specified period of time under which these health care professionals granted disaster privileges may practice on these disaster privileges. This period may not exceed 10 calendar days or the length of the declared disaster, whichever is shorter. At the end of this period the practitioner needs to be converted to Temporary Privileges defined by this policy or be relieved.

(6) A defined process to ensure the verification process of the credentials and privileges of health care professionals who receive disaster privileges that begins as soon as the immediate situation is under control. This process must be identical to the process for granting Temporary Privileges and ultimately result in complete credentialing of these practitioners.

g. **Focused Professional Practice Evaluation.** This is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility.

(1) This is a time-limited period during which the medical staff leadership evaluates and determines the practitioner's professional performance.

(2) Consideration for the focused professional practice evaluation is to occur at the time of initial appointment to the medical staff, or the granting of new, additional privileges. The focused professional practice evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

NOTE: The Focused Professional Practice Evaluation is not a restriction or limitation on the practitioner to independently practice, but rather an oversight process to be employed by the facility when a practitioner does not have the documented evidence of competent performance of the privileges requested.

(3) The criteria for the focused professional practice evaluation process are to be defined in advance, using objective criteria accepted by the practitioner, recommended by the service chief and Executive Committee of the Medical Staff as part of the privileging process and approved by the Director. The process may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.

NOTE: Failure of a practitioner to accept the criteria for the focused professional practice evaluation will result in new privileges not being granted or additional actions taken as appropriate, for currently privileged providers.

(4) Results of the Focused Professional Practice Evaluation must be documented in the practitioner's provider profile and reported to the Executive Committee of the Medical Staff for consideration in making the recommendation on privileges and other considerations.

h. **On-Going Monitoring of Privileges.** 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.

(1) VHA has a robust quality management and performance improvement process. The information collected and analysis of patient care activities under this process is protected by 38 U.S.C. 5705 and may not be used during any portion of the review process for the granting of clinical privileges. The 38 U.S.C 5705-protected materials may trigger the need to perform a more in-depth review of a practitioner.

(2) The criteria that would trigger a more in-depth review must be defined in advance, and be objective, measurable, and uniformly applied to all practitioners with similar privileges.

(3) 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 on-going monitoring program, and compared to pre-defined facility triggers or de-identified quality management data.

i. **Reappraisal and Re-privileging**

(1) **Reappraisal.** Reappraisal is the process of reevaluating the professional credentials, clinical competence, and health status (as it relates to the ability to perform the requested clinical privileges) of practitioners who hold clinical privileges within the facility.

(a) Reappraisal for the granting of clinical privileges must be conducted for each practitioner at least every 2 years. However, reappraisal may be required more frequently for contractors, depending upon the length of the contract period.

1. The reappraisal process must include:

a. The practitioner's statements regarding successful or pending challenges to any licensure or registration;

b. Voluntary or involuntary relinquishment of licensure or registration;

c. Limitation, reduction, or loss (voluntary or involuntary) of privileges at another hospital;

d. Loss of medical staff membership;

e. Pending malpractice claims or malpractice claims closed since last reappraisal or initial appointment;

f. Mental and physical status (as it relates to the ability to perform the requested clinical privileges); and

g. Any other reasonable indicators of continuing qualifications.

NOTE: If there is evidence of pending malpractice cases or malpractice cases closed since last reappraisal or initial appointment, every effort must be made and documented to obtain relevant information regarding the issues involved and the facts of the case(s). The Credentialing and Privileging folder must contain an explanatory statement by the practitioner and evidence that the facility evaluated the facts regarding resolution of the malpractice case(s), as well as a statement of adjudication from the primary source to include, but not limited to: an insurance company, court of jurisdiction, or statement of claim status from the attorney. In the case of the Federal Tort Claims Act (FTCA), information on the adjudication of the case may come from the facility Risk Manager, the Regional Counsel, or the Office of Medical-Legal Affairs.

NOTE: If there is evidence of voluntary or involuntary relinquishment of licensure or registration (as applicable to the position), evidence must be obtained that the practitioner meets VA's licensure requirements (see 38 U.S.C. §§ 7402(b) and (f), and subpar. 5g).

2. Additional information regarding licensure and/or registration status, NPDB-HIPDB PDS report results, peer recommendations, continuing medical education and continuing education unit accomplishments, and information regarding the status of clinical privileges held at other institutions (if applicable) must be secured for review.

a. Peer references are best obtained from those of the same discipline or profession who practice with, and know the practitioner's practice. If possible at least one of the peer references needs to be obtained from someone of the same discipline or profession who can speak with authority on the practitioner's clinical judgment, technical skill, etc.

b. Where there is no one of the same discipline or profession with knowledge of the practitioner's practice, at least one peer reference must be obtained from a health care professional with essentially equal qualifications and comparable privileges with knowledge of the practitioner's performance and practice patterns. Careful consideration needs to be given to avoid the appearance of professional prejudice. A second peer reference can be obtained from a health care professional who has a referral relationship with the practitioner.

c. In instances where at least one peer reference cannot be obtained from a peer of the same profession or a professional with comparable privileges, assistance for the peer reference needs to be sought from the VISN CMO or VHA Program Director for the profession.

NOTE: Information from VA Form 10-2623, or VA Form 3482b, may be considered.

(b) Evaluation of professional performance, judgment, and clinical and/or technical competence and skills is to be based in part on results of provider-specific performance improvement activities. Ongoing reviews conducted by service chiefs must be comprised of activities with defined criteria that emphasize the facility's performance improvement plan, appropriateness of care, patient safety, and desired outcomes and are not protected by 38 U.S.C. 5705. The individual providers' profiles may include provider-specific, non-38 U.S.C. 5705-protected data when applicable. For example, the provider-specific data may include the

following information, when it is not generated as part of a 38 U.S.C. 5705-protected activity: information from surgical case or invasive procedure review; infection control reviews; drug usage evaluation; medical record review; blood usage review; pharmacy and therapeutic review; and monitoring and evaluation of quality, utilization, risk, and appropriateness of care. The relevant provider specific data in these provider profiles can be compared to de-identified aggregate data (like the blood use evaluation summary) as long as the implicit and explicit identification of other providers can not occur. De-identified aggregate data needs to include providers with comparable or similar privileges.

***NOTE:** Materials protected by 38 U.S.C. 5705 may not be used during any portion of the review process for the granting of clinical privileges. The 38 U.S.C 5705-protected materials may trigger the need to perform a more in-depth review; however, quality improvement information that is confidential and privileged in accordance with 38 U.S.C. 5705 may not be used for any part of the reappraisal process even in support of the privileges recommended or granted.*

(c) The reappraisal process needs to include consideration of such factors as the number of procedures performed or major diagnoses treated, rates of complications compared with those of others doing similar procedures, and adverse results indicating patterns or trends in a practitioner's clinical practice. Relevant practitioner-specific data needs to be compared to the aggregate data of those privileged practitioners that hold the same or comparable privileges.

(2) **Re-privileging.** Re-privileging is the process of granting privileges to a practitioner who currently holds privileges within the facility.

(a) This process must be conducted at least every 2 years. However, clinical privileges granted to contractors may not extend beyond the contract period. Each new contract period requires reappraisal and re-privileging. Requests for privileges must be processed in the same manner as initial privileges. Practitioners must request privileges in a timely manner prior to the expiration date of current privileges. ***NOTE:** It is suggested that facilities allow a minimum of 2 to 3 months to process privilege requests.*

(b) The service chief must assess a minimum of two peer recommendations and all other information that addresses the professional performance, judgment, clinical and/or technical skills, any disciplinary actions, challenges to licensure, loss of medical staff membership, changes in clinical privileges at another hospital, health status (as it relates to the ability to perform the requested clinical privileges), and involvement in any malpractice actions. The service chief must document (list documents reviewed and the rationale for conclusions reached) that the results of quality of care activities have been considered in recommending individual privileges and complete the "Service Chief's Approval" in VetPro. Upon completion of this assessment, the service chief makes a recommendation as to the practitioner's request for clinical privileges.

(c) The requested privileges and the service chief's recommendation must be presented, with the supporting credentialing, health status, and clinical competence information, to the medical staff's Executive Committee for review and recommendation. The decision of the medical staff's Executive Committee must be documented (the minutes must reflect the

documents reviewed and the rationale for the stated conclusion) and submitted to the facility Director, as the approving authority, for final action.

(d) Because facility mission and clinical techniques change over time, it is normal that clinical privileges may also change. The service chief must review, with the practitioner, the specific procedures and/or treatments that are being requested. Issues, such as documented changes in the facility mission, failure to perform operations and/or procedures in sufficient number, or frequency to maintain clinical competence in accordance with facility established criteria, or failure to use privileges previously granted, will affect the service chief's recommendation for the granting of new privileges, or the granting of the continuation of privileges. These actions must be considered changes and are not to be construed as a reduction, restriction, loss, or revocation of clinical privileges. Such changes must be discussed between the service chief and the involved practitioner.

(e) Practitioners may submit a request for modification of clinical privileges at any time. Requests to increase privileges must be accompanied by the appropriate documentation, which supports the practitioner's assertion of competence, i.e., advanced educational or clinical practice program, clinical practice information from other institution(s), references, etc. The request must be made through VetPro by opening the electronic record for re-credentialing. In addition to verifying all current credentials and competency associated with this request, active licenses must be verified and a verification of the NPDB-HIPDB PDS reports must be made. Requests for other changes need to be accompanied by an explanatory statement(s). The request for modification of clinical privileges, supporting documents, and practitioner's Credentialing and Privileging folder must be presented to the appropriate service chief for review. The service chief considers the additional information and the entire Credentialing and Privileging folder before making a recommendation to the medical staff's Executive Committee. The medical staff's Executive Committee then presents a recommendation to the facility Director for action.

(f) The process of reappraisal and granting new clinical privileges for facility Directors and COSs is the same as outlined in preceding paragraphs. The facility Director's or COS's request for privileges must be reviewed, and a recommendation made by the relevant service chief responsible for the particular specialty area in which the privileges are requested. When the COS is being considered for privileging, the COS must be absent from the Executive Committee of the Medical Staff deliberations, which an appropriate practitioner chairs. The medical staff's Executive Committee recommendations related to the approval of the requested privileges must be submitted directly to the Director for action, or to the Associate Director who is authorized to act as facility Director for this purpose.

j. **Denial and Non-renewal of Privileges.** This paragraph defines policy and procedures related to the denial or non-renewal of clinical privileges and the requirements for reporting or not reporting such denials to the NPDB.

(1) At the time of initial application and request for clinical privileges, if it is determined for whatever reason that the application should be denied, the credentialing file and appropriate minutes must document that a medical staff appointment is not being made and no privileges

are being granted. Other documentation is at the discretion of the chairman of the committee(s) and the facility Director. A "Do Not Appoint" screen must be completed in VetPro documenting the date of this decision. This denial is not reportable to the NPDB.

(2) At the time of reappraisal and renewal of clinical privileges, privileges that are denied or not renewed based on facility resources must be documented as such in the Credentialing and Privileging file, as well as the appropriate minutes. This action is not reportable to the NPDB.

(3) For all other actions in which clinical privileges requested by a practitioner are denied or not renewed, the reason for denial must be documented. If the reason for denial or non-renewal is based on, and considered to be related to, professional incompetence, professional misconduct, or substandard care, the action must be documented as such and is reportable to the NPDB after appropriate internal VA Medical Center due process procedures for reduction and revocation of privileges, pursuant to this Handbook, are provided (see VHA Handbook 1100.17).

NOTE: VA only reports to the NPDB adverse privileging actions against physicians and dentists (see VHA Handbook 1100.17 and 38 CFR Part 46).

NOTE: 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.

k. **Reduction and Revocation of Privileges.** This paragraph defines policy and procedures related to the reduction and/or revocation of clinical privileges based on deficiencies in professional performance.

(1) Management officials are prohibited from taking or recommending personnel actions (resignation, retirement, reassignment, etc.) in return for an agreement not to initiate procedures to reduce or revoke clinical privileges where such action is indicated. In addition, reporting to the NPDB (including the submission of copies to SLBs) may not be the subject of negotiation in any settlement agreement, employee action, legal proceedings, or any other negotiated settlement. Such agreements or negotiations are not binding on VA and may form the basis for administrative and/or disciplinary action against the officials entering into such agreement or negotiated settlement.

(2) A reduction or revocation of privileges may not be used as a substitute for disciplinary or adverse personnel action. Where a disciplinary or adverse personnel action is warranted, the action against the privileges is to be incorporated into the due process procedures provided for the disciplinary or adverse personnel action.

NOTE: Any situation that results in a practitioner being proctored, where the proctor is assigned to do more than just observe, but rather exercise control or impart knowledge, skill, or attitudes to another practitioner ensuring that patient care is delivered in an appropriate, timely, and effective manner may constitute supervision. If this occurs after initial privileges have been granted, it is considered a restriction on the practitioner's privileges and, as such, is a reduction of privileges and is reportable to the NPDB if proctorship lasts longer than 30 days from the date the privileges are reduced or placed in a proctored status.

(3) General Provisions

(a) These Activities may be Separate from the Reappraisal and Re-privileging process. Data gathered in conjunction with the facility's performance improvement activity is an important tool for identifying potential deficiencies. Material that is obtained as part of a protected-performance improvement program (i.e., under 38 U.S.C. 5705), may not be used during the appraisal process, nor may any reduction or revocation of privileges action 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 must be rediscovered through the administrative review or investigation process.

NOTE: Actions taken against a practitioner's privileges that are not related to professional competence or professional conduct may not be subject to these provisions. Examples of actions that may be considered as not reportable include, but are not limited to, failure to maintain licensure and failure to meet obligations of medical staff membership.

(b) Reduction and Revocation of Privileges. A reduction of privileges may include restricting or prohibiting performance of selected specific procedures, including 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. Revocation of privileges refers to the permanent loss of clinical privileges.

(c) If it becomes necessary to formally reduce or revoke clinical privileges based on deficiencies in professional performance, the procedures indicated in this Handbook must be followed. Procedures for reduction and revocation of clinical privileges are identified in the following paragraphs, and apply to all practitioners included within the scope of this Handbook.

(d) A practitioner who surrenders clinical privileges, resigns, retires, etc., during an investigation relating to possible professional incompetence or improper professional conduct must be reported to the NPDB in accordance with VA regulations 38 CFR Part 46 and VHA Handbook 1100.17. This includes the failure of a practitioner to request renewal of privileges while under investigation for professional incompetence or improper professional conduct.

NOTE: Due process under these circumstances is limited to a hearing to determine whether the practitioner's surrender of clinical privileges, resignation, retirement, etc. occurred during such an investigation. If the practitioner does not request this limited hearing the practitioner waives the right to further due process for the NPDB report and needs to be reported immediately.

(e) Adverse Professional Review Action. Any professional review action that adversely affects the clinical privileges of a practitioner for a period longer than 30 days, including the surrender of clinical privileges or any voluntary restriction of such privileges, while the practitioner is under investigation, is reportable to the NPDB pursuant to the provisions of the VHA policy regarding NPDB reporting.

1. Summary Suspension. Clinical privileges may be summarily suspended when the failure to take such an action may result in an imminent danger to the health of any individual. Summary suspension pending comprehensive review and due process, as outlined in subparagraph 6i, on reduction and revocation, is not reportable to the NPDB. However, the notice of summary suspension to the practitioner needs to include a notice that if a final action is taken, based on professional competence or professional conduct grounds, both the summary suspension, if greater than 30 days, and the final action will be reported to the NPDB. The notice of summary suspension needs to contain a notice to the individual of all due process rights.

a. When privileges are summarily suspended, the comprehensive review of the reason for summary suspension must be accomplished within 30 calendar days of the suspension with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to the facility Director for consideration and action. The Director must make a decision within 5 working days of receipt of the recommendations. This decision could be to exonerate the practitioner and return privileges to an active status, or that there is sufficient evidence of improper professional conduct or incompetence to warrant proceeding with a reduction or revocation process.

NOTE: Proceeding to the reduction or revocation process requires appropriate due process. Guidance should be sought from Regional Counsel and Human Resources to ensure due process is afforded. It is only after the due process is completed, a final action taken by the facility Director, and all appeals have been exhausted that the summary suspension and subsequent reduction or revocation of clinical privileges of a physician or dentist is reported to the NPDB.

b. If the practitioner's clinical privileges are pending renewal and due to expire during a summary suspension or due process procedures for reduction or revocation, the clinical privileges must be denied pending outcome of the review and due process procedures. This denial is considered administrative until such time as a final decision is made in the summary suspension or due process procedures. This final decision determines whether an adverse action has occurred and the responsibility for reporting of the action. If the final action results in what would have been a reportable event, it must be reported in accordance with VHA Handbook 1100.17.

NOTE: See Appendix E for Sample Advisement to Licensed Health Care Professional of Summary Suspension of Clinical Privileges.

2. Independent Contractors and/or Subcontractors

a. Independent contractors and/or subcontractors acting on behalf of VA are subject to the provisions of VA policies on credentialing and privileging and NPDB reporting. In the following circumstances, VA must provide the contractor and/or subcontractor with appropriate internal VA Medical Center due process, pursuant to the provisions of VHA Credentialing and Privileging policy regarding reduction and revocation of privileges, prior to reporting the contractor and/or subcontractor to the NPDB, and filing a copy of the report with the SLB(s) in the state(s) in which the contractor and/or subcontractor is licensed and in which the facility is located:

(1) Where VA terminates a contract for possible incompetence or improper professional conduct, thereby automatically revoking the medical staff appointment and associated clinical privileges of the contractor and/or subcontractor;

(2) Where the contractor and/or subcontractor terminates the contract or subcontract, thereby surrendering medical staff appointment and associated privileges, either while under investigation relating to possible incompetence or improper professional conduct; and

(3) Where VA terminates the services (and associated medical staff appointment and clinical privileges) of a subcontractor under a continuing contract for possible incompetence or improper professional conduct.

b. Where a contract naturally expires, both the medical staff appointment and associated clinical privileges of the contractor and/or subcontractor are automatically terminated. This is not reportable to the NPDB.

c. Where a contract is renewed or the period of performance extended, the contractor and/or subcontractor must be credentialed and privileged similar to the initial credentialing process, with the exception that non-time limited information, e.g., education and training, does not need to be reverified.

3. Automatic Suspension of Privileges. Privileges may be automatically suspended for administrative reasons which may occur in instances where the provider is behind in dictation, or allowed a license to lapse and therefore does not have an active, current, unrestricted license.

a. Such instances must be weighed against the potential for substandard care, professional misconduct, or professional incompetence. A thorough review of the circumstances must be documented with a determination of whether the cause for the automatic suspension does or does not meet the test of substandard care, professional misconduct, or professional incompetence.

b. Under no circumstances should there be more than three automatic suspensions of privileges in 1 calendar year, and no more than 20 days per calendar year. If there are more than three automatic suspensions of privileges in 1 calendar year, or more than 20 days of automatic suspension in a calendar year, a thorough assessment of the need for the practitioner's services needs to be performed and documented and appropriate action taken. Any action is to be reviewed against all reporting requirements.

(f) Procedures Applicable to Administrative Heads. Procedures to reduce and revoke clinical privileges identified within this Handbook are applicable to Directors, COSs, CMOs, and VISN Directors. All responsibilities normally assumed by the COS during the clinical privileging reduction or revocation process must be assigned to an appropriate practitioner who serves as acting chair of the medical staff's Executive Committee. The COS may appeal the Director's decision, or the Director may appeal the Associate Director's decision, regarding the reduction of privileges decision to the VISN Director, just as all practitioners may appeal such a decision. A VISN Director whose clinical privileges to practice at a given facility are reduced or revoked may appeal to the Chief VISN Officer.

NOTE: See Appendix F for Sample Advisement to Licensed Health Care Professional of Automatic Suspension of Clinical Privileges.

(4) Reduction of Privileges

(a) Initially, the practitioner receives a written notice of the proposed changes in privileges from the COS, which notice must include a discussion of the reason(s) for the change. The notice also needs to indicate that if a reduction or revocation is effected based on the outcome of the proceedings, a report must be filed with the NPDB, with a copy to the appropriate SLBs in all states in which the practitioner holds a license, and in the State in which the facility is located. The notice must include a statement of the practitioner's right to be represented by an attorney or other representative of the practitioner's choice throughout the proceedings.

(b) The practitioner must 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 COS's written notice of intent. The practitioner must submit a response within 10 workdays of the COS's written notice. If requested by the practitioner, the COS may grant an extension for a brief period, normally not to exceed 10 additional workdays, except in extraordinary circumstances.

NOTE: Prior to releasing any information to the practitioner or any other individual associated with the review, consultation with the facility Privacy Officer or Regional Counsel is appropriate.

(c) All information is forwarded to the facility Director for decision. The facility Director must make, and document, a decision on the basis of the record. If the practitioner disagrees with the facility Director's decision, a hearing may be requested. The practitioner must submit the request for a hearing within 5 workdays after receipt of decision.

(d) The facility Director must appoint a review panel of three professionals, within 5 workdays after receipt of the practitioner's request for hearing, to conduct a review and hearing. At least two members of the panel must be members of the same profession. If specialized knowledge is required, at least one member of the panel must be a member of the same specialty. This review panel hearing is the only hearing process conducted in connection with the reduction of privileges; any other review processes must be conducted on the basis of the record.

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

2. During such hearing, the practitioner has the right to:

a. Be present throughout the evidentiary proceedings.

b. Be represented by an attorney or other representative of the practitioner's choice.

NOTE: If the practitioner is represented, this individual is allowed to act on behalf of the practitioner including questioning and cross-examination of witnesses.

c. Cross-examine witnesses.

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

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

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

(e) 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.

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

(g) If the practitioner wishes to appeal the Director's decision, the practitioner may appeal to the appropriate VISN Director within 5 workdays of receipt of the facility Director's decision. This appeal option will 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.

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

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

(5) Revocation of Privileges

(a) Recommendations to revoke a practitioner's privileges must be made by the Executive Committee of the Medical Staff, based upon review and deliberation of clinical performance and professional conduct information.

1. A revocation of privileges requires removal from both employment appointment and appointment to the medical staff, unless there is a basis 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. An example could be the revocation of a surgeon's privileges for clinical practice issues, when reassignment to a non-surgical area is beneficial to meeting other needs of the facility.

2. When revocation of privileges is proposed and combined with a proposed demotion or dismissal, the due process rights of the practitioner must be accommodated by the hearing provided under the dismissal process. Where removal is proposed, the due process procedures for removal and revocation of privileges must be combined. Dismissal constitutes a revocation of privileges, whether or not there was a separate and distinct privileging action, and must be reported without further review or due process to the NPDB.

NOTE: Due process under all applicable policies and procedures must be afforded the practitioner. Medical Staff Bylaws may not provide due process in addition to that established by VA. A coordination of all applicable due process procedures in advance will safeguard VA meeting obligations to the practitioner and the Agency in a timely manner. An advance review by Regional Counsel is strongly recommended.

3. When revocation of privileges is proposed and not combined with a proposed demotion or dismissal, the due process procedures under reduction of privileges must pertain.

(b) In instances where revocation of privileges is proposed for permanent employees appointed under 38 U.S.C. 7401(1), the revocation proceedings must be combined with proposed action to discharge the employee under 38 U.S.C., Part V, Chapter 74, Subchapter V, or in accordance with current VA statutes, regulations, and policy.

NOTE: In those instances where the permanent employee was appointed under 38 U.S.C. 7401(3), the revocation proceedings must be combined with proposed action to discharge the employee under VA Handbook 5021, Part 1, Employee/Management Relations, or current VA statutes, regulations, and policy.

NOTE: Practitioners, whose privileges are revoked for substandard care, professional incompetence, or professional misconduct, must be reported to the NPDB in accordance with

the VHA policy on NPDB reporting. In addition, the practitioner's practice must be reviewed for reporting to SLB(s) consistent with VHA policy on SLB reporting.

(c) For probationary employees appointed under 38 U.S.C. 7401(1), the proposed revocation requires probationary separation procedures contained in VA Handbook 5021. For employees appointed under 38 U.S.C. 7405, the proposed revocation requires actions to separate the employee under the provisions of VA Handbook 5021. Where proposed revocation is based on substandard care, professional misconduct, or professional incompetence, the probationary or temporary employee must be provided with the due process procedures that are provided for reduction of privileges, in addition to the procedures contained in VA Handbook 5021 for separation (i.e., the probationary procedures do not afford sufficient due process). When the proposed revocation is based on other grounds, the proposed revocation must be combined with the applicable separation procedures contained in VA Handbook 5021. Practitioners whose privileges are revoked based on substandard care, professional incompetence, or professional misconduct must be reported to the NPDB according to procedures identified in the VHA policy regarding NPDB reporting.

(d) When the revocation of privileges is proposed for practitioners not covered under subparagraphs 6i(3)b and 6i(3)c, consideration must be given to discharging or removing the practitioner, as applicable. It may be desirable to consider other alternatives, such as demotion or reassignment to a position that does not require privileges, where appropriate.

***NOTE:** Revocation procedures must be conducted in a timely fashion. Appropriate action must be taken to see that the practitioner whose privileges are ultimately revoked does not remain in the same position for which the privileges were originally required (see App. G for Sample Advisement to Licensed Health Care Professional of Clinical Practice Review).*

(6) **Management Authority.** Nothing in these procedures restricts the authority of management to temporarily detail or reassign a practitioner to non-patient care areas or activities, thus in effect suspending privileges while the proposed reduction of privileges or discharge, separation, or termination is pending.

(a) The facility Director, acting in the position of Governing Body as defined in the Medical Staff Bylaws, is the final authority for all privileging decisions. This decision must be based on the recommendations of the appropriate Service Chief(s), COS, and/or Executive Committee of the Medical Staff.

(b) Furthermore, the facility Director, on the recommendation of the COS, may summarily suspend privileges, on a temporary basis, when there is sufficient concern regarding patient safety or specific practice patterns.

(c) Nothing precludes VA from terminating a practitioner in accordance with VA Handbook 5021 procedures when the separation is not for a professional reason. Health care professionals appointed under authority of 38 U.S.C. 7405 may be terminated in accordance with VA Directive and Handbook 5021, when this is determined to be in the best interests of VA.

l. **Inactivation of Privileges.** The inactivation of privileges occurs when a practitioner is not being an active member of the medical staff. It is difficult to quantify "extended period of time," but facilities need to consider periods of no clinical practice or continued medical knowledge skills and learning, or when there is no formal clinical relationship between the facility and the practitioner as an extended period of time. Conditions that would be considered reasons for inactivation of privileges may include extended sick leave, and sabbatical with or without clinical practice while on sabbatical. When providers return to the medical center following these circumstances, 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 re-verified. 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.

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

NOTE: Medical staff appointments and privileges will not be granted for a period longer than the formal relationship with the facility. For example, if a contract has a finite end date, privileges may not be granted past the end date of the contract regardless of intent to renew. If a contract is terminated prior to the expiration of the contract, privileges must be terminated since there is no legal agreement for the practitioner to be providing care. Where the contract is terminated early based on substandard care, professional incompetence, or professional misconduct, privileges need to be revoked and a report made to the NPDB, following appropriate due process procedures. Where substandard care, professional incompetence, or professional misconduct is not involved in the early termination of the contract, privileges must be terminated without regard to the due process requirements for privileging actions. This termination is not reportable to the NPDB.

m. **Deployment and/or Activation Privilege Status.** In those instances where a provider is called to active duty, the provider's privileges are to be placed in a Deployment and/or Activation Status. The credential files continue to remain active with the privileges in this new status. If at all possible, this process for returning privileges to an active status must be communicated to providers before deployment.

(1) Providers returning from active duty must be asked to communicate with the medical center staff as soon as possible upon returning to the area. *NOTE: This will hopefully occur with as much lead-time as possible.*

(2) The provider must update the electronic Credentials File after the file has been reopened for credentialing updating licensure information, health status, and professional activities while on active duty.

(3) The credentials file must be brought to a verified status. If the provider performed clinical work while on active duty, an attempt must be made to confirm the type of duties, the provider's physical and mental ability to perform these duties, and the quality of the work; this information must be documented.

(4) The verified credentials, the practitioner's request for returning the privileges to an active status, and the service chief's recommendation are to be presented to the medical staff's Executive Committee for review and recommendation. The decision of the medical staff's Executive Committee must be documented (the minutes must reflect the documents reviewed and the rationale for the stated conclusion) and forwarded to the Director for recommendation and approval of restoring the provider's privileges to Current and Active Status from Deployment and/or Activation Status.

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

(6) In those instances where the privileges lapsed during the call to active duty, the provider needs to provide additional references for verification and the medical center staff needs to perform all verifications required for reappointment.

(7) In those instances where the provider was not providing clinical care while on active duty, the provider in cooperation with the Service Chief, Clinical Executive Board, and/or the Executive Committee of the Medical Center must consider the privileges held prior to the call to active duty and whether a request for modification of these privileges needs to be initiated, on a short-term basis.

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

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

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

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

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

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

NOTE: No step in this process should be a barrier in preventing the provider from returning to the medical center in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994.

7. DOCUMENTATION OF THE MEDICAL STAFF APPOINTMENT AND CLINICAL PRIVILEGES

a. Upon completion of the verification of credentials, recommendations by the appropriate service chief and committee(s), and approval by the Director (acting as the Governing Body), the documentation of the appointment and granting of clinical privileges can be completed. Medical staff appointments and the granting of clinical privileges are to be entered in VetPro and the period may not exceed 2 years. There is no provision for any extension of appointments or privileges.

b. The appointment can be effective as of the date signed by the Director, but may not become effective at a date later than 30 calendar days from the date signed by the Director or 45 calendar days after the recommendation of the Executive Committee of the Medical Staff, whichever is shorter.

NOTE: The timeframes for when the appointment can become effective must comply with all other timeframes established in this policy (see subpar. 5c(4)).

c. The type of employment appointment, i.e., full-time, part-time, WOC, consultant, contract, fee basis, sharing agreement, or other needs be specified, the dates of the appointment, Service and/or Product Line, the Medical Center Director, the signature location of the approval document, and any other appropriate comments are to be entered on the appropriate screens in VetPro including: Service Chief's Approval, Committee Minutes, and Appointment Screens.

d. When indicated, appropriate documentation is to be entered into the Appointment screen of VetPro for less than full appointment, including Temporary and Expedited Appointments.

e. If at the time of initial evaluation, it is determined that no medical staff appointment or clinical privileges will be granted, this action is to be documented in the appropriate supporting documentation at the VA facility, i.e., committee minutes and a "Do Not Appoint" screen must be entered with appropriate comments. The electronic file then needs to be inactivated transferring the file to VetPro VA Central Office.

f. Concurrent Appointments and Sharing of Files

(1) In those instances where a practitioner is providing care at more than one facility, including telemedicine services, medical staff appointments at all facilities need to be coordinated and concurrent.

(2) When the file is reopened for credentialing, each facility at which the provider holds a medical staff appointment needs to start the re-privileging process.

(3) Instructions to the provider need to clearly state that:

- (a) The re-privileging process is going to be done concurrently at all facilities,
- (b) The provider only needs to submit the renewal application in VetPro once, and
- (c) The provider must attest to each facility's Bylaws on the "Sign/Submit" screen.

(4) Each facility needs to consider sharing the practitioner's responses to the Supplemental Questions and the references submitted as part of this coordinated credentials process. In coordinating this effort, the credentialers need to determine who is going to request documentation of any items identified on the Supplemental, the references, and/or peer appraisals.

(5) A facility may not use any time-limited verifications that are obtained prior to the practitioner attesting to the facility's Medical Staff Bylaws. Non-time limited information, such as education or training verification, may be used.

(6) Each facility needs to obtain the license verifications and document registration in the NPDB-HIPDB PDS.

(7) If at any point during the time a practitioner is shared, any of the facilities suspend the practitioner's privileges, or takes an action that is considered to be an adverse personnel, medical staff appointment, or privileging action, the facility taking the action must notify all facilities that share the provider of the action. This notification needs to be made to the COS of each facility for appropriate review and action within the privileges granted at the shared facility.

g. Conversion of Appointments with No Change in Privileges

(1) In those instances where a provider has held a specific employment or medical staff appointment and is being converted to a different type of appointment, either medical staff appointment or Title 38 appointment, the practitioner must apply for this appointment.

(2) Prior to conversion all time-limited information must be verified, regardless of the period of time since previous verification.

(3) The NPDB-HIPDB PDS registration must be confirmed.

(4) The information obtained in this process must be evaluated and reviewed by the appropriate individuals in the same manner as initial appointments or reappraisal. This review must be documented in the appropriate minutes, as well as the credentialing and privileging folder and VetPro. The appointment date remains the same as the previous appointment with the expiration date not to exceed 2 years from that date.

8. REFERENCES

- a. Title 38 U.S.C. 7304, 7401(1)(2)(3), 7402, 7405, 7409, and 7461 through 7464.
- b. Title 45 CFR Part 60.
- c. Public Laws (Pub. L.) 99-166 and 99-660 and its revisions.
- d. Pub. L. 100-177.
- e. Pub. L. 106-117, Section 209.
- f. Pub. L 105-33, Section 4331(c).
- g. Pub. L 104-191, Section 221.
- h. Title 38 CFR Part 46.
- i. Title 5 CFR Parts 315, 731, and 752.
- j. VA Handbook 5005.
- k. VA Handbook 5007.
- l. VA Directive and Handbook 5021.
- m. VA Handbook 6502.1
- n. The Joint Commission, Comprehensive Accreditation Manual for Hospitals.
- o. Privacy Act System of Records Notice for Healthcare Provider Records (77VA10Q).

STANDARD (SIX-PART) CREDENTIALING AND PRIVILEGING FOLDER

1. General Provisions

a. The Credentialing and Privileging folder is the standard system for the establishment and maintenance of credentialing and privileging and related documents, regardless of the employment appointment (e.g., full-time, part-time, without compensation, consultant, contract, fee basis, sharing agreement, or other). Other information related to employment appointment is located in the employee's Official Personnel Folder, or for Title 38 employees who have personnel folders, in the Merged Records Personnel Folder (MRPF). The contents of the folder are based on requirements outlined in the Veterans Health Administration (VHA) Handbook 1100.19, Credentialing and Privileging.

b. The facility Chief of Staff is responsible for maintenance of the Credentialing and Privileging system. The folder must be kept active as long as the practitioner is employed by the Department of Veterans Affairs (VA) facility. If the practitioner transfers to another VA facility, the folder must transfer to the new location.

2. Format and/or Filing Sequence

a. The model folder provided to all facilities by the Chief Medical Director (now the Under Secretary for Health) on April 9, 1991, represents a practitioner who has held appointment or been utilized to provide on-station patient care for more than 2 years. An appropriate Credentialing and Privileging folder is to be established for each practitioner regardless of the length of service. The specific sections of the standard folder are identified as:

- (1) Section I. Application and Reappraisal Information.
- (2) Section II. Clinical Privileges.
- (3) Section III. Professional Education and Training.
- (4) Section IV. License(s).
- (5) Section V. Professional Experience.
- (6) Section VI. Other Practice Information.

b. Sections I and II provide for a complete overview of the individual practitioner's qualifications, type of appointment and clinical privileges. Sections III through VI represent the support documents to the information presented in Sections I and II. All documents are to be filed in the order specified.

**OCCUPATIONS COVERED BY TITLE 38 UNITED STATES CODE (U.S.C.)
SECTION 7402(F), REQUIREMENTS**

1. The following list of occupations and job series indicates whether a State license (L), certification (C), or registration (R) is required by the statute, regulation, or Veterans Health Administration (VHA) qualification standard.

2. For those individuals hired on or after November 30, 1999, the date to be used to determine the individual's eligibility is the date the credential requirement was implemented. For example, the Department of Veterans Affairs (VA) first required the credential in 1972, the individual lost the credential in 1983, and the individual applies, or was appointed, to VA after November 30, 1999, the individual is not eligible for VA employment in the covered position unless the lost or surrendered credential is restored to a full and unrestricted status. However, if the individual lost the credential in 1970, before it was a VA requirement, eligibility for VA employment would not be affected.

Occupation	Series	L, C, Date 1st Required
Chiropractor*		6/16/2004
Expanded Function Dental Auxiliary (EFDA)	682	7/1/1982
Psychologist*	180	8/10/1982
Social Worker	185	6/25/1992
Physician	602	1/3/1946
Nurse	610	1/3/1946
Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN)	620	2/8/1972
Physical Therapist	633	10/29/1982
Pharmacist	660	1/3/1946
Optometrist*	662	8/14/1952
Podiatrist*	668	11/8/1966
Dentist	680	1/3/1946

* May be practicing as an licensed independent provider but still subject to Title 38 United States Code (U.S.C.) 7402(f)

3. There are a number of professions both on this list and not found on this list, but identified in paragraph 2 of this Appendix for whom there are proposed changes to the VHA Qualification Standards. If a requirement for state issued L, C, or R is added as a new requirement, the conditions of 38 U.S.C. 7402(f) are effective as of the date the credential is required.

GUIDANCE ON WHEN TO QUERY THE FEDERATION OF STATE MEDICAL BOARDS

1. **Initial Appointment.** The applicant for an initial medical staff appointment must be screened against the Federation of State Medical Boards (FSMB) disciplinary files by direct computer access using VetPro in accordance with the following procedures (see diagram in App. D for guidance in the decision making process). The only exception to this is for those providers being appointed in accordance with Temporary Medical Staff Appointments for Urgent Patient Care Needs.

a. The physician must submit a complete VetPro application.

b. To allow for the greatest matching ability in the query of the FSMB disciplinary file, the *Education* screen must be in a verified status either through verification of education or, for International medical graduates, the Educational Commission for Foreign Medical Graduates (ECFMG) screen must be in a verified status prior to the submission of the query. VetPro does not allow for a query to be submitted if one of these two screens is not in a verified status.

c. The facility designee, e.g., the credentialing staff, must submit the electronic query through the VetPro FSMB Query screen of the provider's record.

d. VetPro electronically receives the response from the FSMB and appends it to the *License* screen. If there is no match on the query, this is displayed on the VetPro *License* screen similar to the no match response received from the National Practitioner Data Bank (NPDB) – Health Integrity and Protection Data Bank (HIPDB) stating “*No Match.*” If there is a match to the FSMB query, the response, a Portable Document Format (PDF) file, is retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat 5.0 for viewing and printing.

2. **Reappointment.** Those practitioners who held Department of Veterans Affairs (VA) medical treatment facility medical staff appointments and were enrolled in VetPro prior to April 26, 2002, have been submitted to the FSMB for screening against the FSMB Disciplinary Files by VA Central Office during the national review of appointed practitioners in May 2002, if the necessary information was available in VetPro. Confirmation of this query or identification of need to query must be in accordance with the following procedures (see App. D).

a. For those providers for whom there was a *Match* with the FSMB Disciplinary Files, reports were forwarded to the appropriate facility for scanning in to the *Licensure* screen. For those providers who had not submitted credentialing information through VetPro when the report was returned to the facility it may have been screened in to the *Personal Profile* screen.

b. Where the VA Central Office screening produced *No Match*, VA facilities are being provided the information for documenting that a query was made, the date of the query, and the query batch number. Facilities were directed to document this information on a Report of Contact on the VetPro *Licensure* screen.

c. If through this process there is no documented query of the FSMB:

(1) The *Education* screen must be in a verified status either through verification of education or for international medical graduates, the *ECFMG* screen must be in a verified status prior to the submission of the query. **NOTE:** *VetPro does not allow for a query to be submitted if one of these two screens is not in a verified status.*

(2) The facility designee, e.g., the credentialing staff, must submit the electronic query through the VetPro FSMB Query screen of the provider's record.

(3) VetPro receives the response from the FSMB and appends it to the *License* screen. If there is no match on the query, this is displayed on the VetPro *License* screen similar to the no match response received from the NPDB-HIPDB stating "No Match." If there is a match to the FSMB query, the response, a PDF file is retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat 5.0 Reader for viewing and printing.

3. Temporary Medical Staff Appointment for Urgent Patient Care Needs. In those instances where there is a documented urgent patient care need requiring a temporary medical staff appointment, a query to the FSMB must be performed in accordance with the following procedures.

a. The VetPro *Temporary Enrollment* Screen must be completed by the VA Medical Center staff.

b. The facility designee, e.g., the credentialing staff, must submit the electronic query through the VetPro FSMB Query screen of the provider's record.

c. VetPro receives the response from the FSMB and appends it to the *License* screen. If there is no match on the query, this is displayed on the VetPro *License* screen similar to the no match response received from the NPDB-HIPDB stating "No Match." If there is a match to the FSMB query, the response, a PDF file, is retrievable through the VetPro *License* screen and it can be viewed when VetPro launches Adobe Acrobat 5.0 Reader for viewing and printing.

4. On-station Contract Practitioners. On-station contract practitioners must be screened against the FSMB Disciplinary Files through VetPro for each appointment to each VA facility. This screening must be documented each time on the *Licensure* screen (see App. D). The only exceptions to this requirement are:

a. There has been no clinical practice between VA facility assignments, and

b. The time between VA facility assignments is less than 30 calendar days

5. Break in Service. If a practitioner has a break in service greater than 30 days or has practiced medicine during any break in service regardless of the length of time, a new screening against the FSMB Disciplinary Files is required. Files that have been previously archived

through inactivation in the VetPro system and are re-activated for medical staff appointment at a VA facility require a new screening against the FSMB Disciplinary Files. In both instances, this screening against the FSMB Disciplinary Files must be in accordance with this Handbook.

a. Those practitioners who have been screened against the FSMB Disciplinary Files by VA Central Office, or will be screened through VetPro, must be placed in VHA's FSMB Disciplinary Alerts Service. Those practitioners entered into the VHA's FSMB Disciplinary Alerts Service, are continuously monitored. Any orders reported to the FSMB from licensing entities, as well as the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) and the Department of Defense (DOD), initiate an electronic alert that an action has been reported to the Veterans Health Administration (VHA)'s Credentialing and Privileging Program Director.

(1) The registration of practitioners into this system is based on these queries and only on these queries.

(2) This monitoring is on-going for registered practitioners.

(3) Alerts received by VHA's Credentialing and Privileging Program Director must be forwarded to the appropriate VA facility for primary source verification and appropriate action. The disciplinary information that pertains to the practitioner can then be downloaded and forwarded to the appropriate facility for review and inclusion in the practitioner's credentials file.

(4) Practitioner names must be removed from the VHA FSMB Disciplinary Alerts Service when:

(a) The practitioner file is inactivated in VetPro.

(b) The practitioner medical staff appointment lapses in VetPro.

(c) In either of these instances, notation must be made in the VetPro file on the VetPro *Appointment* screen of removal from the VHA FSMB Disciplinary Alerts Service. Such a notation requires a new query to the FSMB Disciplinary Files; if the provider is appointed in VHA at a future time the practitioner's name must be placed back into the monitoring process.

b. The FSMB must invoice each VA facility for the queries made on a monthly basis.

November 14, 2008

VHA HANDBOOK 1100.19
APPENDIX D

**DECISION PROCESS FOR QUERIES OF THE FEDERATION OF
STATE MEDICAL BOARD**



Decision Process for
Queries of the Feder:

November 14, 2008

VHA HANDBOOK 1100.19
APPENDIX E

**SAMPLE ADVISEMENT TO LICENSED HEALTH CARE PROFESSIONAL OF
SUMMARY SUSPENSION OF PRIVILEGES**

Date

John Doe, M.D.
1234 East Main
Little Town, Big State 12345

Dear Dr. Doe:

This is to notify you that your privileges are summarily suspended effective this date. This action is being taken upon the recommendation of the Chief of Staff since concerns have been raised to suggest that aspects of your clinical practice do not meet the accepted standards of practice and potentially constitute an imminent threat to patient welfare. ___ (Insert general statement on reason for summary suspension)___ This suspension is in effect pending a comprehensive review of these allegations.

You have the opportunity to provide any information you desire to provide regarding these concerns. Correspondence should be addressed to:

Appropriate Contact
Department of Veterans Affairs
123 Street
Anytown, USA 12345

This should be sent within 14 calendar days from your receipt of this notice.

The comprehensive review of the reasons(s) for the summary suspension must be accomplished within 30 calendar days of the suspension, with recommendations to proceed with formal procedures for reduction or revocation of clinical privileges forwarded to me for consideration and action. Within 5 working days of receipt of the recommendations, I will make a decision either to restore your privileges to an active status or that the evidence warrants proceeding with a reduction or revocation process. Since you cannot perform clinical duties during the review, you are removed from patient care and placed ___ (in an administrative position or on administrative leave, as applicable)___.

Should the comprehensive review result in a tentative decision by me to restrict or revoke your privileges, and if appropriate, to take an adverse personnel action, you will be notified at that time of your rights as per VHA Handbook 1100.19 and VA Directive and Handbook 5021. You have a right to be represented by an attorney or other representative of your choice throughout the proceedings.

Summary suspension pending comprehensive review and due process is not reportable to the National Practitioner Data Bank (NPDB). However, if a final action against your clinical

privileges is taken for professional incompetence or improper professional conduct, both the summary suspension and the final action, if greater than 30 days, will be reported to the NPDB, and a copy of the report must be sent to the State licensing boards in all states in which you hold a license and in ___(Insert State in which facility is located)___.

If you surrender or voluntarily accept a restriction of your clinical privileges, including by resignation or retirement, while your professional competence or professional conduct is under investigation during these proceedings or to avoid investigation, VA is required to file a report to the NPDB, with a copy to the appropriate State licensing board(s), pursuant to VA regulations in Title 38 Code of Federal Regulations (CFR) Part 46 and VHA Handbook 1100.17, National Practitioner Data Bank Reports.

It is the policy of VA to report to State Licensing Boards those licensed health care professionals, whether currently employed or separated (voluntarily or otherwise), whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients (see 38 CFR Part 47). In the event you are found to not meet standards of care, consideration will be given whether, under these criteria, you should be reported to the appropriate State Licensing Board(s) pursuant to the provisions of VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards.

If you have any questions, please contact ___(Insert contact information)___.

Sincerely yours,

Medical Center Director

November 14, 2008

VHA HANDBOOK 1100.19
APPENDIX F

**SAMPLE ADVISEMENT TO LICENSED HEALTH CARE PROFESSIONAL OF
AUTOMATIC SUSPENSION OF CLINICAL PRIVILEGES**

Date

John Doe, M.D.
1234 East Main
Little Town, Big State 12345

Dear Dr. Doe:

This serves as notification that effective ___(Insert date)___, your clinical privileges have been administratively suspended based on the recommendation of the Professional Standards Board or Medical Executive Committee (MEC) due to ___(Insert justification, such as delinquent dictations, expired license)___ . Corrective action should be accomplished within ___(Insert #)___ days of receipt of this notice. Once the ___(Insert issue)___ has been corrected, the Executive Committee of the Medical Staff will review your credentialing information and make a recommendation regarding reinstatement of your privileges. Until that time, you are removed from patient care and placed in an administrative position or on administrative leave. This action is being taken in accordance with the ___(Insert Facility name)___ Medical Staff Bylaws. The circumstances will be thoroughly reviewed to determine if the reason for this administrative suspension meets the criteria for substandard care, professional misconduct, or professional incompetence. This will then be reviewed against all reporting requirements.

Please note that a practitioner may not have more than three automatic suspensions in 1 calendar year, and no more than 20 days per calendar year. If either of these occurs, a review of the need for the practitioner's continued services will be performed.

Please sign and date the acknowledgment on the next page return it to the Office of the Chief of Staff by close of business today.

Should you have any questions or wish to discuss this issue, please feel free to contact the Chief of Staff.

Sincerely yours,

Medical Center Director

cc: Service or Product Line Chief

Advisement of Automatic Suspension of Clinical Privileges

Acknowledgement of Receipt of Advisement of Automatic Suspension of Clinical Privileges by
____(Insert Professional's Name, Title)____

I, _____ acknowledge receipt of this notification.
(Printed name)

(Signature of recipient)

(Date)

One requirement is that the Advisement must be mailed Certified Mail, Return Receipt Requested, or hand delivered, but the professional must sign a copy of the Advisement as an acknowledgement of receipt or there must be other evidence of receipt.

November 14, 2008

VHA HANDBOOK 1100.19
APPENDIX G

**SAMPLE ADVISEMENT TO LICENSED HEALTH CARE PROFESSIONALS OF
CLINICAL PRACTICE REVIEW**

Date

John Doe, MD
1234 East Main
Little Town, Big State 12345

Dear Dr. Doe:

This is to notify you that a review is being conducted of your clinical privileges. Concerns have been raised regarding your professional conduct or competence that suggest such conduct affects or could affect adversely the health or welfare of a patient, or patients. ____ (Insert general statement on reason for review) ____.

In accordance with VHA Handbook 1100.19, Credentialing and Privileging, and the ____ (Insert Facility Name) ____ Veterans Health Care System Medical Staff Bylaws, Fair Hearing and Appellate Review, you will be extended "due process" rights.

A review will be initiated to determine if your privileges could be adversely affected. You will be allowed to review all evidence not restricted by regulation or statute, collected by the review process upon which any proposed adverse action is based. Following that review, you may respond in writing to my written notice of intent. You must submit a response within 10 working days of receipt of written notice. If you request, I may grant an extension for a brief period, normally not to exceed 10 workdays, except in extraordinary circumstances.

All information collected during the review will be forwarded to the facility Director for decision. The facility Director will make, and document, a decision on the basis of the record. Full and impartial consideration will be given to your reply if a reply is submitted. If you disagree with the facility Director's decision, you may request a hearing. You must submit the request for a hearing within 5 workdays after receipt of decision.

If you request a hearing, the facility Director will appoint a review panel of three professionals, within 5 workdays after receipt of your request for hearing, to conduct a review and hearing. At least two members of the panel will be members of your same profession. If specialized knowledge is required, at least one member of the panel must be a member of your specialty. This review panel hearing will be the only hearing process conducted in connection with the adverse privileging action; any other review processes will be conducted on the basis of the record. You will be advised in writing of the date, time, and place of the hearing.

During such hearing, you have the right to be present throughout the evidentiary proceedings, represented by an attorney or other representative of your choice, and to question and cross-examine witnesses. You have the right to purchase a copy of the transcript of tape of the hearing.

The panel will complete the review and submit the report within 15 workdays from the date of the close of the hearing. The facility Director may allow additional time for extraordinary circumstances or cause. The panel's report, including findings and recommendations regarding privileges and whether disciplinary action should be initiated, will be forwarded to the facility Director, who has the authority to accept, reject, accept in part, or modify the review panel's recommendation.

The facility Director will issue a written decision within 10 workdays of the date of the receipt of the panel's report. If your privileges are reduced, the written decision will indicate the reason(s). The facility Director's signature constitutes a final action, and if the reduction is for a period longer than 30 days on grounds related to professional incompetence or improper professional conduct, the reduction is reportable to the National Practitioner Data Bank (NPDB), with a copy to be sent to the appropriate State Licensing Boards in all states in which you hold a license(s) and in the State of ___(Insert State in which facility resides)__. This adverse action report to NPDB will be filed within 15 days after the privileging action is made final by the facility Director. Prior to approving the report, the facility Director will notify you and provide you with an opportunity for discussion. The NPDB will send a copy of the computerized report to you with a limited comment period. You are not able to submit changes to the report however. If you wish to appeal the decision, you may appeal to the Veterans Integrated Service Network (VISN) ___(Insert VISN #)___ Director within 5 workdays of receipt of the facility Director's decision. This appeal option will not delay the submission of the NPDB report. If the facility Director's decision is overturned by the ___(Insert VISN #)___ Director, the report to the NPDB will be withdrawn.

The ___(Insert VISN #)___ Director will provide a written decision, based on the record, within 20 workdays after receipt of your appeal. The decision of the VISN Director is not subject to further appeal.

Should you surrender or voluntarily accept a restriction of your clinical privileges, or resign or retire from your medical staff position with the Department of Veterans Affairs (VA) while your professional competence or professional conduct is under investigation during these proceedings or to avoid investigation, such action is required to be reported without further review or due process to the NPDB and the appropriate State Licensing Boards.

It is the policy of VA to report to State Licensing Boards those licensed health care professionals, whether currently employed or separated (voluntarily or otherwise), whose clinical practice during VA employment so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. (see Title 38 Code of Federal Regulations (CFR) Part 47 Part 47). In the event you are found to not meet standards of care, consideration will be given whether, under these criteria, you should be reported to the appropriate State Licensing Board(s) pursuant to the provisions of VHA Handbook 1100.18,

Reporting and Responding to State Licensing Boards.

Sincerely yours,

Chief of Staff

NOTE: The general statement of reason for review should be sufficient to enable the professional to understand what actions were involved and the nature of the concerns that have arisen from the actions.

a. The Advisement is be mailed Certified Mail, Return Receipt Requested, or hand delivered. The professional needs to sign a copy of the Advisement as an acknowledgement of receipt or there must be other evidence of receipt.

b. Consideration must be given to whether a personnel action also should be taken. Where a disciplinary or adverse action is warranted, the action to reduce or revoke privileges should be combined with the due process for the personnel action. Revocation of privileges requires removal from both employment appointment and appointment to the medical staff unless there is a basis to reassign the practitioner to a position not requiring clinical privileges

c. When revocation of privileges is proposed for permanent employees appointed under Title 38 United States Code 7401(1), based on professional conduct or competence grounds, the due process procedures for revocation of privileges must be combined with a proposed removal action. The notice letter for the removal action should advise that if a reduction or revocation of clinical privileges is effected based on the outcome of the dismissal proceedings, VA will file an adverse action report with the NPDB, with a copy to the State Licensing Board(s) in all States in which the practitioner holds a license and in the State in which the facility is located.