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PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT TO THE CLINICAL STAFF AND DETERMINATION OF APPROPRIATE CLINICAL PRIVILEGES

INTRODUCTION: The credentialing process verifies a practitioner’s credentials and competencies for the purpose of determining appropriate clinical privileges and Clinical Staff membership.

1. This Credentialing and Privileging Manual (“Manual”) does not replace or modify the Amended and Restated Bylaws of the Clinical Staff of the University of Virginia Medical Center (“Bylaws”), or any policy of the University of Virginia Medical Center contained in the Medical Center Policy Manual.

2. The Medical Center’s Credentials Committee is a standing committee of the Clinical Staff Clinical Staff Executive Committee. The Credentials Committee functions primarily to review, evaluate and make recommendations concerning membership on the clinical staff and the competency and qualifications of practitioners who request clinical staff privileges. The Credentials Committee also serves as the investigatory body for all matters set forth in Article VII of the Bylaws. The President-Elect of the Clinical Staff serves as chair of the Credentials Committee.

3. All recommendations relating to Clinical Staff appointments, reappointments, the granting of clinical privileges, modifications of Clinical Staff status and/or clinical privileges are made by the Credentials Committee. All such recommendations are reviewed and approved/disapproved by the Clinical Staff Executive Committee (“CSEC”) and then submitted to the Medical Center Operating Board (“MCOB”) for approval/disapproval.

4. The University of Virginia Medical Center Clinical Staff database is an electronic record of a practitioner’s credentials and history including licensure, malpractice carrier(s) and litigation history, DEA registration, education, hospital affiliations, disciplinary sanctions, evaluations of competency, and performance measures tracked by the Medical Center’s performance/quality improvement program and such other information that the Credentials Committee determines to be necessary. The database assists in the standardized collection and verification of a practitioner’s credentials and is information reviewed and evaluated by the Credentials Committee in determining the competency and qualifications of practitioners for professional staff privileges. All information in the electronic database is confidential and privileged under Virginia Code Section 8.01-581.17.

I. Clinical Staff Membership

The Bylaws state that the Clinical Staff includes those physicians, dentists, podiatrists, Ph.D. Clinical Psychologists and Ph.D. Clinical Pathologists who hold a faculty appointment in the School of Medicine and have obtained membership status in the manner provided in the Bylaws. Section 3.3 of the Bylaws creates the following categories of Clinical Staff membership: Attending Clinical Staff, Administrative Clinical Staff, Honorary Clinical Staff and Ph.D. Clinical
Pathologist Staff. The qualifications for holding each of these appointments, permissible authority and duties that may be assigned for each of these categories and limitations on authority for each of these categories are set out in Sections 3.5, 3.6, 3.7 and 3.8 of the Bylaws.

The Clinical Staff Office shall gather all information required to determine whether applicants for clinical staff membership have met the relevant requirements of Sections 3.5.1, 3.6.1, 3.7.1 or 3.8.1 of the Bylaws.

II. Clinical Staff Privileges

The categories of clinical staff privileges and authority within each category are:

**Attending privileges:** Members of the Clinical Staff may be granted attending privileges. Attending privileges authorize the Clinical Staff Member to admit patients to the Medical Center and participate fully in the care of Medical Center patients within the scope of specific privileges granted.

**Consulting privileges:** Physicians, dentists, podiatrists and Ph.D. Clinical Psychologists who will participate in patient care activities at the Medical Center at the request of a Member who holds attending privileges may be granted consulting privileges. A non-member with consulting privileges may consult regarding care to patients only as specifically delineated in his or her clinical privileges. A non-member with consulting privileges shall not admit patients to an inpatient facility of the Medical Center.

**Visiting privileges:** Physicians, dentists, podiatrists and Ph.D. Clinical Psychologists who will participate in patient care activities in the Medical Center for a time-limited period at the request of a Member who holds attending privileges may be granted visiting privileges. A non-member with visiting privileges may participate, as applicable, in the care of patients, educational activities and research facilities within the scope of his or her delineated clinical privileges.

**Temporary privileges:** Temporary privileges shall be granted in only two circumstances: (a) when an important patient care need mandates an immediate authorization to practice, and (b) when the Credentials Committee has recommended and has approved an applicant’s request for privileges but the Clinical Staff Executive Committee and the MCOB have not yet approved the recommendation. Temporary privileges granted under (b) shall not exceed 120 days. See Section 5.7 of the Bylaws. The conditions set out in Section 5.7.3 of the Bylaws shall apply to all applicants to whom temporary privileges are granted.

**Emergency privileges** may be granted to a clinician in the case of unpredictable emergencies which have resulted in the activation of the Medical Center Emergency Management Plan in order to allow the clinician, to the degree permitted by his or her license, to perform services to save the life of a patient(s), using every facility of the Medical Center necessary, including the calling of any consultation. When the emergency situation no longer exists, any such clinician must apply for the staff privileges necessary to continue to treat the patient(s).
III. Procedures for Initial Appointment and Issuance of Privileges

When the Dean and a Department Chair have mutually agreed upon an applicant for his/her Department, the Dean and the Chair jointly shall forward a request for Clinical Staff appointment and issuance of privileges to the Clinical Staff Office. The Clinical Staff Office shall follow the procedures set out in Attachment A. Attachment A specifies all information required for Credentials Committee consideration of requests for clinical staff membership and issuance of clinical privileges. Mandatory timelines for providing such information are included in Attachment A.

Every initial application for clinical privileges shall contain a detailed listing of the specific clinical privileges requested. The Credentials Committee shall evaluate each such request based upon the applicant’s education, training, experience, demonstrated competence, references and other information specified in Attachment A.

The applicant has the burden of producing all required information, of resolving any questions about the information and of responding to requests for additional information.

The applicant shall sign an acknowledgement of his/her agreement:

(a) to provide appropriate continuous care and supervision of his/her patients;

(b) to abide by the Bylaws of the Clinical Staff, all policies in the Medical Center Policy Manual, the Code of Conduct and all other applicable rules, regulations or policies;

(c) to accept committee assignments, as applicable;

(d) to release from liability, to the extent permitted by law, all persons for their acts performed in connection with evaluating the applicant;

(e) to submit to a mental or physical health examination as requested by the Credentials Committee, and

(f) to abide by the other requirements of this Manual and the requirements contained in the Appointment Acceptance Form as such may be amended from time to time.

Medical Center Policy No. 0221 requires that physicians who are members of the Medical Center Clinical Staff must be Board Certified and re-certified by the Medical Specialty Board for the specialty or each subspecialty within which they practice, as determined to be appropriate by the Credentials Committee. Medical Center Policy No. 0221 permits requests for exemption from this requirement for limited specified reasons. Attachment B is Medical Center Policy No. 0221.

Upon receipt and review of all required credentialing documentation, the Department Chair and the Credentials Committee shall recommend to CSEC that such applicant should be granted/denied Clinical Staff appointment and recommend the specific clinical privileges to be
issued. CSEC shall review the Credentials Committee’s recommendation and all applicable documentation. If the CSEC approves the granting of Clinical Staff membership and clinical privileges to the applicant, the favorable recommendation shall be forwarded to the MCOB for final action. Article VIII of the Bylaws sets forth the applicable procedures and due process rights of the applicant when the recommendation is unfavorable.

The initial grant of clinical privileges shall be for one year. The initial grant of privileges is provisional for all practitioners. During the one year period, the applicant’s performance and clinical competence shall be observed by the Department Chair or his/her designee.

IV. Procedures for Reappointment and Renewal of Privileges

Following the provisional period, requests for reappointment and renewal of clinical privileges for a practitioner shall be submitted by the Department Chair every two years in the manner set out in Attachment C. Criteria to be considered at the time of reappointment and renewal of clinical privileges include specific information derived from the department’s direct observation of care provided, review of records of patients, review of the records of the Department Clinical Staff as compared to the records of the particular Member and an appropriate comparison of the performance of the practitioner with his/her professional colleagues in the Department. See Medical Center Policy No. 0279 (Attachment D). Data collected by the Quality/Performance Improvement Program shall also be considered at the time of any request for reappointment and renewal of privileges.

Attachment C specifies all information required for Credentials Committee consideration of requests for reappointment to the Clinical Staff and renewal of clinical privileges. Mandatory timelines for providing such information are included in Attachment C.

The applicant for reappointment has the burden of producing all required information, of resolving any questions about the information, responding to requests for additional information and signing an acknowledgement:

(a) to provide appropriate continuous care and supervision of his/her patients;

(b) to abide by the Bylaws of the Clinical Staff, all policies in the Medical Center Policy Manual, the Code of Conduct and all other applicable rules, regulations or policies;

(c) to accept committee assignments, as appropriate;

(d) to release from liability, to the extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) to submit to a mental or physical health examination as requested by the Credentials Committee, and
(f) to abide by the other requirements of this Manual and the requirements contained in the Appointment Acceptance Form as such may be amended from time to time.

Medical Center Policy No. 0221 requires that physicians who are members of the Medical Center Clinical Staff must be Board Certified and re-certified by the Medical Specialty Board for the specialty or each subspecialty within which they practice, as determined to be appropriate by the Credentials Committee. Medical Center Policy No. 0221 permits requests for exemption from this requirement for limited specified reasons. Attachment B is Medical Center Policy No. 0221.

Upon receipt and review of all required re-credentialing documentation, the Credentials Committee shall recommend to CSEC that such practitioner should be granted/denied Clinical Staff reappointment and recommend the specific clinical privileges to be issued. CSEC shall review the Credentials Committee’s recommendation and all applicable documentation. If CSEC approves the granting of Clinical Staff membership and clinical privileges to the applicant, the favorable recommendation shall be forwarded to the MCOB for final action. Article VIII of the Bylaws sets forth the applicable procedures and due process rights of the applicant when the recommendation is unfavorable.

If the Clinical Staff office does not receive completed re-credentialing documentation from the Clinical Department requesting reappointment and renewal of clinical privileges, the Department Chair’s office will be notified by the Clinical Staff Office of the date upon which clinical privileges will end.

Reappointments and renewal of clinical privileges shall be for a period not to exceed two years.

V. Interim Credentialing Matters

The practitioner and Department Chair shall notify the Clinical Staff Office in writing of any changes in a practitioner’s qualifications for clinical privileges as those changes relate to possible additions, reductions, restrictions and/or other changes in specific privileges. The Credentials Committee shall consider whether the written information supports or requires a change in the clinical privileges granted to the practitioner.

As provided in Section 7.5 of the Bylaws, a practitioner’s Clinical Staff membership and privileges may be automatically suspended or limited by the president or President-Elect of the Clinical Staff, the Chair of the Credentials Committee or the Chief Executive Officer of the Medical Center for lapse, disciplinary action or any change in any of the following:

(a) licenses authorizing practice in Virginia

(b) DEA permit status

(c) lack of adequate professional liability insurance

(d) Federal Program exclusion
(e) loss of faculty appointment

The Clinical Staff Office will regularly review the listing of disciplinary actions provided by the Virginia Board of Medicine, Virginia Board of Dentistry and Virginia Board of Psychology and will query the Medicare/Medicaid sanctions list at the time of reappointment or if there are changes to a practitioner’s privileges. Relevant information from these inquiries shall be reported to the Credentials Committee.

When a practitioner resigns his/her faculty appointment prior to the end of his/her current grant of clinical privileges or when the practitioner will not be reappointed to his/her faculty position, the practitioner’s Clinical Department shall notify the Credentials Committee of the date at which the appointment ends. Clinical privileges automatically expire with the termination of a faculty appointment.

VI. Grant of Privileges without Clinical Staff Membership

Clinical privileges may be granted to qualified practitioners who are not members of the Clinical Staff in the situations specified below. All practitioners granted clinical privileges under these provisions shall comply with the Bylaws of the Clinical Staff and with all Medical Center policies, procedures and guidelines.

(a) Emergency privileges required by activation of Medical Center emergency management plan.

(1) Emergency privileges may be granted when the emergency management plan has been activated and the Medical Center is unable to handle the immediate patient needs.

(2) During disaster(s) in which the emergency management plan has been activated, the Chief Executive Officer or the President of the Medical Staff or the Chair of the Credentials Committee has the option to grant emergency privileges. The grant of privileges under such circumstances is not required and rests within the discretion of the specified individuals.

(3) Decisions as to the scope of privileges shall be made on a case by case basis and shall reflect the specific patient needs that exist during the activation of the emergency management plan as well as the education, training, and experience of the practitioner.

(4) When the Medical Center’s emergency management plan is activated, the Chief Executive Officer or the President of the Medical Staff or the Chair of the Credentials Committee may grant specific privileges upon a practitioner’s presentation of any one of the following:

i. A current picture hospital ID card.

ii. A current license to practice and a valid picture ID issued by a state, federal or regulatory agency.

iii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team.
iv. 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.

v. Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner’s identity.

(5) As soon as the immediate situation necessitating activation of the Medical Center’s emergency management plan is under control, the Clinical Staff Office shall begin the process of verifying credentials, following the procedures outlined in Section III of this Manual.

(6) When emergency privileges are granted under this provision, there shall be a member of the Clinical Staff who has been granted active clinical privileges assigned to monitor the performance of the practitioner to whom emergency privileges have been granted. The monitor shall report to the Clinical Staff Office, on a daily basis, with an assessment of the practitioner’s clinical skills.

(7) Any practitioner to whom emergency privileges are granted shall be required to wear a name tag identifying him/her as holding emergency privileges only.

(8) Emergency privileges shall automatically expire when the emergency management plan is deactivated.

(b) Non-members who may be granted Visiting privileges shall consist of Physicians, Dentists, Podiatrists, Ph.D. Clinical Psychologists, and Ph.D. Clinical Pathologists who will participate in patient care activities in the Medical Center for a time-limited period at the request of an Attending Member of the Clinical Staff, with the support of his or her Chair.

(1) The Clinical Staff Office shall follow the procedures set out in Attachment A.

VII. Hearings and Appeals

Article VIII of the Amended and Restated Bylaws sets out all applicable hearing and appeal rights.

VIII. Reporting of Information

As required by Title IV of the Health Care Quality Improvement Act of 1986, the University of Virginia Medical Center will disclose to the National Practitioner Data Bank (“NPDB”) certain information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. Information disclosed to the Data Bank and State Medical and Dental Boards will be limited to information that is required by law to be disclosed, as defined below. The Clinical Staff Office shall be responsible for submitting required information to the NPBD. Attachment E sets out the process to be followed for such reporting.

Medical Center Policy No. 0255, Mandatory Reporting of Healthcare Practitioners, (Attachment F) specifies the procedures to be followed for mandatory reporting to Virginia’s health regulatory boards.
IX. Release of Privileging/Credentialing Information

The Clinical Staff Office maintains the Credentials Committee’s proceedings, minutes, and records as well as records of all communications, both oral and written, originating in or provided to the Credentials Committee. All such proceedings, minutes, records and communications are privileged under Virginia Code § 8.01-581.17 because the Credentials Committee is a committee that functions primarily to review, evaluate and make recommendations about the competency and qualifications for professional staff privileges of practitioners providing care and treatment at the University of Virginia Medical Center.

The privilege that attaches to these proceedings, minutes, records and communications is a privilege afforded to the Medical Center under Virginia law. The privilege cannot be waived by a practitioner who may be the subject of the proceedings, minutes, records and communications.

The Credentials Committee may allow review of the proceedings, minutes, records and communications maintained by the Clinical Staff Office if such review is in furtherance of the processes of reviewing and evaluating information concerning a practitioner’s competency and qualifications for clinical staff privileges.

The Credentials Committee has authorized the following access to information:

(a) A practitioner who holds clinical privileges at the Medical Center may review his/her credentials/privileging file only if such review is in furtherance of the Credentials Committee processes.

(b) A department Chair may review the credentials/privileging file of a member of the clinical staff of his/her department only if such review is in furtherance of the Credentials Committee processes.

(c) The Chair of the Credentials Committee, a member of the Credentials Committee, Medical Center executive management or legal counsel may review the file of any practitioner holding clinical privileges at the Medical Center whenever the purpose is related to his/her role in the privileging/credentialing process.

(d) Staff of the Clinical Staff Office may review credentials/privileges files as necessary to carry out their job responsibilities.

(e) Internal auditors for the Commonwealth, the University, and the Medical Center and individuals acting in connection with national accreditation organizations (such as JCAHO or other accrediting bodies) and/or state and federal health oversight entities may be permitted to review files in connection with their official duties. Any such request for review must be presented to and approved by the Credentials Committee. The Committee may impose such terms on such review as it deems appropriate.

Rules and procedures for review of information maintained by the Clinical Staff Office are set out in Attachment G.
Attachment A
Initial Appointment and Issuance of Privileges

Clinical Staff Appointment Timeline

16 weeks
- Faculty position added; Dept selects candidate
- Dean’s Office sends offer letter, contract, request for privileges letter, & faculty packet to Clinical Staff Office (CSO)

15 weeks
- CSO sends packet to applicant with all forms
- CSO sends HSF New Faculty Form to Dept
- Dept returns New faculty Form to CSO; data is entered in CSO database & form is sent to HSF

12 weeks
- Applicant returns materials
- CSO distributes materials from applicant; HSF applies for billing numbers

10 weeks
- CSO requests verifications
- Dept returns privilege form to CSO
- CSO sends file to Credentials Committee

4 weeks
- Credentials Committee sends recommendations to CSEC / MCOB

3 weeks
 Procedures of Initial Appointment and Issuance of Privileges

The initial appointment process is begun when the Dean’s Office sends the offer letter, UPG contract, Department’s request for privileges letter and faculty packet to the Clinical Staff Office (CSO).

The CSO sends the offer letter and UPG contract to the applicant along with the following credentialing documents via Federal Express to the applicant’s home address, unless otherwise specified by the Department:

- Billing application forms for third party payers
- Information for scheduling UPG Compliance Training and health screening with UVA WorkMed
- Request for Clinical Privileges (Core Privileges form)
- Request for Laser Privileges (if applicable)
- Typical Patient Topic form
- Pre-paid Federal Express label and return envelope
- Cover Letter with instructions on how to access CSO website to complete documents for requesting appointment to the Clinical Staff and clinical privileges.

  **Credentials Application Packet:** Please access our website to complete the following documents for requesting appointment to the Clinical Staff and clinical privileges:
  
  http://www.healthsystem.virginia.edu/internet/clinicalstaff/credentialing.cfm

  1. Clinical Staff Membership Application
  2. Electronic Access Agreement
  3. Physician Acknowledgement Statement
  4. PLT Professional Liability Coverage Memo and Form

The applicant is asked to provide the following when returning the completed credentialing packet:

- Additional documentation for any credentialing questions which were answered “yes”
- Copy of permanent Virginia medical license with expiration date and license number legible
- Copy of current medical license issued by other states
- Notarized copy of current DEA registration
- Copy of photo ID, i.e. driver’s license or passport
- Copy of specialty and subspecialty board certificates
- ECFMG Certificate (if applicable)
- Updated curriculum vitae
When the completed credentialing packet is received in the CSO:

The original offer letter is sent to the Dean’s Office with a copy the applicant’s CV and the Faculty Personal Data Sheet.

The original UPG contract, Exhibit A and Split Payroll Forms are sent to UPG. Copy of the applicant’s Virginia license, DEA, Specialty Board Certification(s), MD degree or transcript, and CV are scanned into CACTUS.

The Department is sent the New Clinical Faculty Fact Sheet to complete, original moving agreement if department it to reimburse, and the original CORE Privileges Form (and Laser Privilege Form if applicable) for careful review of privileges requested. The privileges form is reviewed by the Department’s Division Head/QI Liaison and signed by the Department Chair. The original signed form is returned to the CSO.

The Department receives copies of the following credentialing forms for the department’s files:

- Application for Clinical Privileges
- Virginia License
- DEA Registration
- Board Certificate(s)
- MD degree or transcript
- Reference Letters
- Outside Privilege Letters/Verifications
- Curriculum Vitae

UPG makes application for the provider’s billing numbers.

The CSO obtains the following verifications:

- Documentation for “yes” responses to the confidential questions
- Two references from persons with knowledge of professional competence and character
- Clinical privileges held at other institutions
- Virginia license is current and in good standing
- Licenses from other states are in good standing
- ABMS Board Certification(s)
- Malpractice coverage dates and claims history for previous 10 years
- Office of Inspector General Exclusions/Fraud, Protection, and Detection Listing
- Excluded Parties List
- Treasury Department (Terrorists) Listing
- National Practitioner Database Healthcare Integrity and Protection Data Bank
- Education (MD degree and postgraduate training)
- ECFMG Certification (if applicable)
- NPI (National Plan & Provider Enumeration System)
When all credentialing documentation has been obtained, the physician has completed UPG Compliance Training and health screening results have been received in the CSO, the physician is eligible to go through the process for granting temporary privileges. The department Administrator and HR contact is sent email notification when temporary privileges are granted and the physician is sent a formal letter of notification. Please note: Temporary privileges are full privileges, but indicate the physician’s clinical appointment is pending approval with the Credentials Committee, the Clinical Staff Executive Committee and the Medical Center Operating Board.

The CSO sends Piedmont Liability Trust the PLT application, copy of malpractice verifications and CV.

The Credentials Committee meets, discusses any issues and approves the list presented. The approved list is then forwarded to the CSEC Committee for approval and then to MCOB for final approval. After MCOB, reappointment letters and acceptance forms are generated and sent to the clinical staff, with a copy sent to the Department Chair.

**Exceptions to Requirements for Clinical Staff Membership**

**DEA Registration**

The Clinical Staff are required to obtain and keep current their own DEA Registration. If the physician’s clinical practice does not require prescribing of controlled substances, the Department Chair must submit a request in writing to the Chair of the Credentials Committee asking that the physician be exempt from having DEA registration. The Department Chair’s request is submitted to the Credentials Committee for consideration at their next meeting. Subsequent to the meeting the Department Chair is sent a letter communicating the Committee’s decision.

**ABMS Board Certification**

Medical Center Policy No. 0221 permits requests for exemption from the requirement for ABMS Board Certification for the specialty or each subspecialty within which the physician practices. Please refer to Policy No. 0221 (Attachment B) for details on the limited specified reasons under which exceptions may be requested and the process for submitting the request.

**Focused Professional Performance Evaluation (FPPE)**

The competence of a practitioner who is new to the Medical Center will be evaluated during the first 90 days of the initial privileging period. The Department Chair will ensure completion of the FPPE Form at the end of the designated review period and report the results to the Credentials Committee. The Credentials Committee will consider the results of the focused evaluation in its decision to recommend termination of privileges requested by the individual practitioner.
Attachment B
Medical Center Policy No. 0221

Clinical Staff Executive Committee

MEDICAL CENTER POLICY NO. 0221

A. SUBJECT: Board Certification Requirements for Medical Center Physicians

B. EFFECTIVE DATE: January 1, 2011 (R)

C. POLICY:

Physicians who are members of the Clinical Staff of the University of Virginia Medical Center must be Board Certified and re-certified\(^1\) by the Medical Specialty Board for the specialty or each subspecialty within which they practice, as determined to be appropriate by the Medical Center’s Credentials Committee. The certifying Board must be a member of the American Boards of Medical Specialties.

D. PROCEDURE:

1. Members of the Clinical Staff shall submit proof of Board Certification, and re-certification, to the Department Chair and to the Clinical Staff Office. Failure to maintain ABMS board certification may result in loss of clinical privileges.

2. The Credentials Committee may consider claims that extraordinary circumstances have prevented the physician from attaining Board certification or re-certification. To support such a claim, the Department Chair shall submit written documentation that provides factual support of extraordinary circumstances, including but not limited to disability, illness or military service, that may warrant granting an extension of time for the physician to become board certified or to recertify.

3. For those specialty board examinations that will be given for the first time on or after December 2007, the Credentials Committee shall require each physician practicing in the affected specialty or subspecialty to submit a plan specifying the process by which he/she will attain board certification. The Credentials Committee shall review the submitted plan and the applicable ABMS requirements for certification and either approve or request modification of the plan.

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\(^1\) When re-certification is required by the Medical Specialty Board.
(SUBJECT: Board Certification Requirements for Medical Center Physicians)

4. If a physician does not pass a specialty board certification or recertification examination within two consecutive examination periods, the physician shall be ineligible for and/or shall lose clinical privileges absent a showing of extraordinary circumstances.

5. Requests for exceptions to requirements for Board Certification, and re-certification, will be considered by the Credentials Committee. Such requests shall be in writing and must include, at a minimum, a letter from the physician’s Department Chair specifying which of the below listed permissive exceptions is sought and giving the factual basis for recommending an exception. Additional information supporting the request may also be provided, as required by Paragraph 6 below or as otherwise appropriate. The Credentials Committee will review the request and supporting documentation and provide a written response specifying the reasons for recommending approval or denial of the request. The Credentials Committee’s recommendation shall be presented to the Clinical Staff Executive Committee and to others as specified below. Granting of board exemption by the Credentials Committee does not absolve the physician from obtaining ABMS certification at the earliest possible time when the applicant has met ABMS board requirements.

6. Exceptions may be requested by a Department Chair with the specified supporting documentation and shall be approved by the Credentials Committee only as follows:

a. The physician began clinical practice in a specialty before Board Certification for the specialty was available or before re-certification was required; the physician was “grandfathered” for purposes of Board Certification and the physician has continued to practice in his or her specialty.

i. Written requests for this exemption must be submitted to the Clinical Staff Office by both the applicant and the Department Chair. The request must specify when the physician began practice and Board Certification was first available or re-certification required.

ii. The Department Chair (or the Dean if the physician is a Department Chair) where the physician holds a primary appointment shall set forth details about the physician’s length of practice, expertise in specialty area, and competence that support the request.

iii. Another member of the Clinical Staff must also submit a letter or other writing providing factual support for the request for an exemption.

b. The physician has met the ABMS specialty board requirements to sit for the examination, but has not been out of training long enough or satisfactorily met the attending clinical experience/procedures required by primary or secondary certification board to have been able to take the appropriate board examination once or, in case of failure, twice. If such a physician is granted clinical privileges, the Department Chair shall provide the Credentials Committee with a plan for the evaluation of the physician’s competence through written reports. The Credentials Committee will determine the frequency of monitoring on a case-by-case basis. These reports are to parallel the Board criteria for certification and include the number of patients treated and their outcomes.

c. The physician will bring a new diagnostic or therapeutic area to the University of Virginia Medical Center or is similarly exceptionally qualified.
(SUBJECT: Board Certification Requirements for Medical Center Physicians)

i. The Department Chair shall provide to the Chair of the Credentials Committee documentation to support the claim that the physician is exceptionally qualified and that an exception to the Board certification requirement should be granted. The Chair will consult with and seek approval of the President of the Clinical Staff, Dean of the School of Medicine, and the Chief Executive Officer of the Medical Center, as appropriate, for any such exception.

ii. Upon approval by the Dean, the President of the Clinical Staff, and the Chief Executive Officer of the Medical Center, as appropriate, the Department Chair shall provide to the Chair of the Credentials Committee documentation to support the claim that the physician is exceptionally qualified and that an exception to the Board certification requirement should be granted.

iii. If such a physician is credentialed, the Department Chair shall provide the Credentials Committee with a plan for the subsequent re-evaluation of the physician’s competence through written reports. The Credentials Committee will determine frequency of monitoring on a case-by-case basis. These reports should parallel the Board criteria for re-certification. If the exception is for a Departmental Chair, the Dean shall appoint a tenured peer to perform the evaluation.

d. The physician will provide specific services that are needed by the Medical Center to serve a critical patient population and the physician will be supervised under a plan that is approved by the Credentials Committee.

i. The Department Chair shall provide to the Credentials Committee sufficient documentation to support the claim that the physician will provide services that are needed by the Medical Center to serve a critical population and a proposed plan of supervision for the physician. The number of patients requiring the service should be estimated. Sufficient documentation may include, but is not limited to:

a) the estimated or projected volume of patients/procedures per year and/or;

b) an estimate of the minimum number of patients/procedures required for the practitioner to maintain or perfect the clinical skills necessary to competently perform the procedures. This estimate shall be based upon the experience of other hospital centers that perform the procedure and/or;

c) data showing that the volume, or expected volume, of patients/procedures per year exceeds current physician staffing as compared to similar staffing at other comparable institutions and/or;

d) documentation of efforts to recruit and retain ABMS certified clinicians and/or;
e) documentation of a shortage of ABMS certified clinicians.

(SUBJECT: Board Certification Requirements for Medical Center Physicians)

ii. The candidate shall have taken and passed appropriate specialty board examinations for which he/she is qualified.

iii. The Department Chair will consult with and obtain approval of the President of the Clinical Staff, Dean of the School of Medicine, and the Chief Executive Officer of the Medical Center, as appropriate, for any such exception.

iv. If such a physician is credentialed, the Department Chair shall provide the Credentials Committee with a plan for the subsequent re-evaluation of the physician’s competence through written reports. The Credentials Committee will determine the frequency of monitoring on a case-by-case basis. These reports are to parallel the Board criteria for re-certification and include the number of patients treated and their outcomes.

SIGNATURE:

DATE:

Medical Center Policy No. 0221 (R)
Approved September 2, 1997
Reviewed April 2001
Approved by Credentials Committee
Approved by Clinical Staff Executive Committee
Attachment C
Reappointment and Renewal of Privileges

Clinical Staff Reappointment Timeline

16 weeks Prior to CCM
(20 weeks for July 1 reappointments)
- Spreadsheet created with upcoming reappointments, date changes and resignations
- Quality & Performance Improvement Department prepares quality data reports for current reappointments

8 weeks Prior to CCM
(12 weeks for July 1 reappointments)
- Clinical Staff Office (CSO) sends recredentialing packets & quality data reports to Departments

4 weeks Prior to CCM
(8 weeks for July 1 reappointments)
- Completed recredentialing packets are received in CSO
- CSO requests verifications
- CSO contacts Departments about packets not returned by deadline

CCM
- CSO contacts Credentials Committee
- CSO sends files to Credentials Committee
- Credentials Committee sends recommendations to CSEC / MCCB
**Procedures for Reappointment and Renewal of Privileges**

All reappointments must be approved by the Medical Center Operating Board (MCOB) prior to the beginning of the next appointment period. As a result, approval by the Credentials Committee and the Clinical Staff Executive Committee (CSEC) must take place one month prior to MCOB approval at the very latest. Reappointment paperwork will be sent to Departments at least 2 months prior to the projected Credentials Committee approval month. This allows one month for processing by the Department and one month for the Clinical Staff Office (CSO) to complete verifications. Please note, the July reappointments are sent out the first week of January to allow the Department and CSO extra time for processing the large number of reappointments that occur at this time.

2 months prior to the projected delivery of the reappointment paperwork to the departments

A spreadsheet is created for the next quarter reappointments listing the primary and secondary department reappointments, date changes and resignations. The spreadsheet is emailed to Quality and Performance Improvement who will produce quality data reports for the individuals on the list. The target delivery date for receipt of the quality data and the delivery of the reappointment paperwork to the Departments is set at this time.

2 - 4 weeks prior to the projected delivery of the reappointment paperwork to the departments

Reappointment packets are prepared containing the following documents:

- Standard Evaluation Form
- Application for Clinical Staff Reappointment (3 pages)
- Clinical Privileges Update Form (stapled to a copy of the previous privilege form)
- Release of information
- Notes regarding UPG Compliance Training, UPG Contract renewal and Board Certification status.

Reappointments are batched by Department with coversheets. The Quality Data and reappointment packets are hand-delivered together to the departments. Receipt of the Quality Data in the department is acknowledged by signing and dating the cover page.

The CSO assigns online UPG Compliance Training modules to the current reappointments.

(The Martha Jefferson Hospitalists, Lynchburg Nephrologists and Harrisonburg Nephrologists have special instructions for printing and distribution of their packets.)
One month after the reappointments packets have been delivered most will have been completed and returned to the CSO. The CSO will follow-up with the department to obtain those packets that have not been received by the requested return date.

Piedmont Liability Trust will provide letters documenting any claims history for the current reappointments.

Processing of recredentialing entails verification of the following:

- Documentation for “yes” responses to the confidential questions and requests for additional privileges (*see note below)
- Clinical privileges held at other institutions are in good standing
- Claims history and status of open claims
- Malpractice coverage provided by outside companies
- Virginia license is current and in good standing
- Licenses from other states are in good standing
- ABMS Board Certification(s)
- Medicare/Medicaid Exclusions
- Federal Excluded Parties List
- National Practitioner Databank
- UPG Compliance Training completed
- Department confirms end date of next UPG contract renewal (** see note below)

*Documentation for yes responses and requests for additional privileges are brought to the Director’s attention to be discussed with the Chair of the Credentials Committee prior to the Credentials Committee meeting.

** When a contract is not executed for the length of time stated by the department at the time of reappointment, a date change is processed so the reappointment end date and contract end date coincide whenever possible.

The Credentials Committee meets, discusses any issues and approves the list presented. The approved list is then forwarded to the CSEC Committee for approval and then to MCOB for final approval. After MCOB, reappointment letters and acceptance forms are generated and sent to the clinical staff, with a copy sent to the Department Chair.

A document called the Additions/Deletions List is created from the approved Credentials Committee list. The OR and UVA Outpatient Surgery Center receive a copy of the Additions/Deletions list, reappointment letter, and privilege update form for applicable departments.
Ongoing Professional Performance Evaluation (OPPE)

Ongoing Professional Practice Evaluations shall begin immediately after appointment to the Clinical Staff and provide continuous monitoring of the practitioner’s clinical performance. Each Clinical Department Chair will implement the appropriate process and will have specific performance criteria to be tracked for each Clinical Staff member within the Department, some of which will be organization wide criteria and some of which will be Department specific criteria.
A. SUBJECT: Professional Practice Evaluations for Members of the Clinical Staff

B. EFFECTIVE DATE: January 1, 2011 (R)

C. POLICY:

In order to improve and promote safe, high quality clinical care and to comply with regulatory requirements, the Medical Center shall evaluate the competence of all Members of the Clinical Staff with clinical privileges (“practitioners”) in the Medical Center through Professional Practice Evaluations (as defined in this Policy). All practitioners with clinical privileges in the Medical Center, as a condition to receiving and continuation of those privileges, shall participate in Professional Practice Evaluations, including serving as proctors or evaluators from time to time.

Professional Practice Evaluations are a process of reviewing, evaluating and making recommendations as to the adequacy and quality of professional services, as well as the competency and qualifications for professional staff privileges. All proceedings, minutes, records and reports of the Professional Practice Evaluation process are privileged and confidential to the full extent authorized by Virginia Code § 8.01-581.17 and are also exempted from production under Section 2.2-3705.1(1) of the Virginia Freedom of Information Act.

D. DEFINITIONS:

1. Core Privileges: Patient care, including diagnostic techniques, medical management, and procedures, which a practitioner would be qualified to perform upon completion of an accredited residency program or other training program as approved by the Department Chair. The applicable Medical Center Department Chair or Division Chief is responsible for defining the core privileges for his/her department.

2. Non-Core Privileges: Patient care, including diagnostic techniques, medical management, and procedures, which fall outside the core privileges for a given specialty and for which additional training is required. The applicable Medical Center Department Chair or Division Chief is responsible for defining the core privileges for his/her department.

3. Focused Professional Practice Evaluation or Focused Evaluation (“FPPE”): A process whereby the Medical Center evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege, or when a question arises regarding the ability of a currently privileged practitioner to provide safe, effective high quality care. Focused professional practice evaluation is a time-limited period.
during which the Medical Center evaluates and determines the practitioner’s professional performance and may be undertaken in a number of ways, including through Peer Review.

4. Ongoing Professional Practice Evaluation or Ongoing Evaluation (“OPPE”): A process that allows the Medical Center to identify professional practice trends of practitioners with privileges in the Medical Center that impact on quality of care and patient safety on an ongoing basis and focuses on the individual member’s performance and competence related to his or her Clinical Staff privileges. The process evaluates the quality, adequacy and competency of an individual practitioner’s performance and thus is a central part of the institutions’ clinician peer review process.

5. Professional Practice Evaluation (“PPE”): Any one or combination of Focused Professional Practice Evaluation or Ongoing Professional Practice Evaluation. These terms include activities traditionally referred to as ‘peer review’.

6. Peer: A practitioner whose interest and expertise as documented by clinical practice or academic rank and/or post graduate degree(s) is reasonably determined to be equivalent in scope and emphasis to that of another practitioner.

7. Peer Review: The traditional term for the process of reviewing, evaluating and making recommendations as to the adequacy and quality of professional services, as well as the competency and qualifications for professional staff privileges. In this Policy, the term “Professional Practice Evaluation”, which incorporates traditional peer review, is adopted because it better reflects the use of data on practice patterns to review and evaluate the competency and qualifications of practitioners.

8. Professional Practice Evaluation Subcommittee (“PPES”): A subcommittee of the Credentials Committee charged with reviewing, evaluating and making recommendations concerning the adequacy and quality of practitioner professional clinical practice and competency and qualifications for clinical privileges. Members of the PPES shall be appointed by the President of the Clinical Staff and the Vice President and Chief Executive Officer of the Medical Center and shall include representatives from the Credentials Committee and the Quality Committee. The chair of PPES shall be appointed by the chair of the Credentials Committee. The PPES shall report to the Credentials Committee.

E. PROCEDURE:

1. Focused Professional Practice Evaluation Process – New Privilege Situation. When a practitioner initially requests a privilege, whether at the time of initial appointment, reappointment, or between reappointment cycles, he or she shall submit documentation of clinical experience and specialized training to support his or her competency and qualifications. When such information is not available or there is not enough evidence to verify the privilege-specific competency of the practitioner within 90 days of the initial grant of privileges, a Focused Evaluation will be utilized.

   a. For practitioners seeking initial privileges at the Medical Center, the Focused Evaluation will consist of:

      (i) from the training program director, Department Chair and/or Division Chief at the applicant’s current institution, verification of competency in all skills, behaviors and procedures considered to compose the CorePrivileges of the specialty or subspecialty of practice;

      (ii) specific verification of competency in skills, behaviors and procedures
considered to exist outside the Core Privileges (Non-Core Privileges) for the specialty or subspecialty of practice as requested by the Credentials Committee when new privilege(s) are granted;

(iii) review of practitioner-specific quality data by the Department Chair or Division Chief with the physician 90 days after the initial appointment;

(iv) verification to the Credentials Committee by the Department Chair or Division Chief at the conclusion of the 90 day period that the performance of the practitioner is within acceptable standards and consideration of this verification by the Credentials Committee; if the Department Chair or Division Chief determines that additional time is needed to complete the Focused Evaluation then the period shall be extended for up to 90 days. The Credentials Committee shall be notified of this extension and shall consider whether this extension shall affect the practitioner’s privileges. At the conclusion of this extended period, the Department Chair or Division Chief shall notify the Credentials Committee of the outcome of the FPPE and the Credentials Committee shall use this information in review of the practitioner’s clinical privileges;

b. For practitioners who have clinical privileges in the Medical Center but are seeking to add a new privilege, the Focused Evaluation will consist of:

(i) documentation submitted by the Clinical Staff Member and the Department Chair or Division Chief to the Credentials Committee of clinical experience and specialized training to support his or her competency and qualifications; or

(ii) in the absence of the information in (i) above, or in addition to that information if requested by the Credentials Committee, the practitioner will undergo a case review process for an initial period of 90 days based on processes and procedures defined by the applicable Department or Division and acceptable to the Credentials Committee.
2. **Focused Professional Practice Evaluation Process - Triggering Events.** A Focused Evaluation may also be initiated when a single or sentinel event occurs and/or patterns or trends indicate potentially unsafe patient care. Any member of the Clinical Staff or any other person who believes a practitioner is unable to provide safe, quality patient care may request in writing such an assessment to the Clinical Department Chair, Division Chief, Senior Associate Dean for Clinical Affairs, Medical Director of Quality and Performance Improvement, President of the Clinical Staff, Chair of the Credentials Committee, Vice President and Dean of the School of Medicine or the Vice President and Chief Executive Officer of the Medical Center.

All such requests shall be forwarded to the Chair of the PPES and to the Clinical Staff Office. The Chair of the PPES shall refer the matter to the appropriate Clinical Department Chair or Division Chief, requesting that he/she assess the practitioner's performance and report back to the PPES. The Clinical Department Chair may exercise discretion regarding the need for FPPE based upon his/her direct knowledge of the practitioner, the nature of the concern and the history of prior concerns/complaints regarding that practitioner. The Chair may delegate responsibility for carrying out FPPE to the appropriate Division Chief or Chiefs within the Department. The events, patterns or trends for a Focused Evaluation in this circumstance include both global and department-specific triggers as defined below:

a. **Global:**

(i) a request in writing describing concerns related to the ability of a practitioner to provide safe quality patient care, submitted as described above;

(ii) mortality measures: Evidence of a pattern of unexpected death, as demonstrated by a severity-adjusted mortality index significantly above that of the institutional peer group, death in low-mortality diagnosis-related groups, and/or assignation of preventable death after departmental mortality review. In some circumstances, a single unexpected death may be considered to warrant a FPPE;

(iii) morbidity measures: Evidence of a pattern of unexpected serious but non-fatal injury, as demonstrated by rates of serious adverse events, patient safety indicators, or hospital-acquired complications (including, but not limited to: new onset peri-procedural myocardial infarction, neurologic injury, renal failure, thromboembolism, or injury to vital organs), at a rate significantly exceeding that of the institutional peer group. In some circumstances, a small number of serious complications may be considered to warrant a FPPE;

(iv) sentinel events (as defined by The Joint Commission) if the root cause analysis suggests the event may have been precipitated by cognitive or behavioral deficit of the practitioner;
(v) excessive number of patient complaints as determined by Departmental QI evaluations;

(vi) Quality report trends and patterns involving concerns about a practitioner’s performance, including professional behavior (based on nature and number);

(vii) Concerns about practitioner health or fitness to practice, including concerns about substance abuse or other impairment, as determined by the Department Chair, Division Chief or the Physician Wellness Program;

(viii) concerns about patterns or trends in rate-based indicators in the Physician Quality Dashboard showing significant variance from the institutional peer group, including but not limited to: (a) rate of unplanned readmission within 30 days after discharge for complication or incomplete management of problem during previous admission (allocation to the appropriate attending physician), (b) use frequency of reversal agents, (c) severity adjusted length of stay indices, (d) cost per case indices, or (e) final discharge order by 9 AM (F09) and/or discharge by noon (DBN) rates;

(ix) excessive aggregate rate of medical record deficiencies and/or electronic signature attestation (ESA) deficiencies as compiled through electronic authentication audits;

(x) practices that deviate significantly from established clinical practice or operational standards/guidelines established by the Quality, Patient Care or Credentials Committees, e.g. usage of restraints, anticoagulants, DVT/PE prophylaxis, informed consent, infection control policies and procedure, new privilege and low volume practitioner policies;

(xi) cases determined through departmental quality/peer review group to warrant FPPE;

(xii) initiation of an investigation by the Department of Health Professions or an action taken by the Virginia Board of Medicine, the Virginia Board of Dentistry or the Virginia Board of Psychology and based upon the nature of the complaint and the action taken.

b. Department or Division specific:

(i) any area of competency regularly reviewed as a component of an Ongoing Professional Practice Evaluation for which an individual practitioner is outside the Clinical Department or Division benchmark standards, or for whom an unfavorable trend is noted over two cycles of the Ongoing
c. A Focused Evaluation is time limited as determined by the Clinical Department Chair. In general a Focused Evaluation should be completed in 90 days, except as circumstances otherwise warrant (e.g., the need for an external evaluator or a particularly complex evaluation). If after the designated review period, competency assessment is not yet verified, the evaluation may be extended or a different type of evaluation process may be initiated. The evaluation period shall proceed until such time as: (i) satisfactory evidence exists to support the practitioner’s competence to perform the requested privilege or (ii) performance improvement has occurred. However, if the Department Chair concludes that satisfactory evidence of competence has not been produced and/or that performance improvement has not occurred, he/she shall recommend to the Credentials Committee a modification of the practitioner’s clinical privileges.

d. Information to be considered in a Focused Evaluation may include, but is not limited to:


a. Ongoing Professional Practice Evaluations shall begin immediately after the grant of clinical privileges to a practitioner to practice in the Medical Center and provide continuous monitoring of the practitioner’s clinical performance. It is the responsibility of each Clinical Department Chair to implement the appropriate process for Ongoing Professional Practice Evaluations within his or her Department as contemplated by this Policy. The Clinical Department Chair may delegate this responsibility to the appropriate Division Chief or Chiefs within the Department.
b. Each Clinical Department will have specific practice-specific metrics including internal and external benchmarking to be tracked for each practitioner within the Department, some of which will be organization wide criteria and some of which will be Department specific criteria. The organization wide criteria (e.g. Physician Quality Dashboard data and global triggers) will be based in principle on the Joint Commission core competencies of patient care, medical knowledge, practice based leaning and improvement, interpersonal and communication skills, professionalism and systems based practice. The Department of Quality and Performance Improvement will work with each Clinical Department to develop the performance information in dashboard format and will provide the dashboard information for the Department or Division to the Department Chair, applicable Division Chiefs and the Credentials Committee every six months. Each Department shall maintain this information in a separate quality file for each physician and in a secure location.

c. Each Clinical Department Chair or Division Chief, as appropriate, will review the physician-specific dashboards as one way to evaluate the performance of practitioners within the particular Department or Division. Individual practitioner evaluations will be based on the specified benchmark criteria for the Department or Division as well as other information specific to the practitioner from sources such as periodic chart review, direct observation, monitoring of diagnostic and treatment techniques and/or discussion with other individuals involved in the care of each patient including consulting physicians, assistants at invasive or high risk procedures, nursing, and administrative personnel.

d. If there is uncertainty regarding the practitioner’s professional performance, a Focused Evaluation or assessments by internal or external peers of the practitioner may be undertaken in accordance with this Policy or corrective action may be pursued in accordance with Article VII of the Medical Center Clinical Staff Bylaws, as deemed appropriate.

e. At the time of re-credentialing of an individual practitioner, all of the practice evaluation data will be considered by the Clinical Department Chair, the Division Chief, as applicable, and the Credentials Committee.

4. Professional Practice Evaluation Subcommittee. The PPES shall:

a. Assure that the Professional Practice Evaluation is conducted in a manner that is objective, equitable and consistent. The Subcommittee shall require that (1) case selection is done by use of pre-selected indicators; (ii) review of cases is performed by committee in accordance with established procedure that has been approved by the Credentials Committee, (iii) follow-up is conducted in accordance with procedures approved by the Credentials Committee and reported to the Medical Center Operating Board Quality Subcommittee.

b. Review regularly and at random, the results of FPPE and OPPE on individual practitioners.

c. Make recommendations to the Credentials Committee regarding the status of the FPPE and OPPE processes in the clinical departments.
d. Make recommendations to the clinical departments as to how they could improve the FPPE and OPPE processes.

e. Review the results of all FPPE and OPPE processes which result in recommendations for restriction of privileges or practice.

f. Submit an annual report to the Credentials Committee concerning compliance with the requirements of this Policy.

g. Review and recommend revision of Medical Center policy regarding Professional Practice Evaluations periodically or as required by regulations or accrediting bodies.

h. Maintain confidentiality of Professional Practice Evaluation data, documents and work products.

Attendance will be kept for meetings of the Professional Practice Evaluation Subcommittee. Members who do not maintain attendance at 50% of the meetings over a six month period will be replaced.

5. Conflict of Interest. A practitioner who is asked to perform a Professional Practice Evaluation may have a conflict of interest if the practitioner may not be able to render an unbiased opinion. An absolute conflict of interest would result if the practitioner were the provider under review. Relative conflicts of interest may be due to a practitioner’s involvement in the patient’s care not related to the issues under review or because of a relationship with the practitioner involved. However, simply being a member of the same Clinical Department or Division as the practitioner under review may not constitute a conflict of interest. In any case where a practitioner who has been requested to perform a Professional Practice Evaluation believes that he or she may have a conflict of interest or there is any doubt, the practitioner should disclose the situation to the Chair of the PPES who has the responsibility to determine on a case-by-case basis if a relative conflict or potential relative conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial relative conflict is determined to exist, then the individual may not participate or be present during the review body discussions or decisions other than to provide specific information requested by the review body.

6. Privilege and Confidentiality

All proceedings, minutes, records and reports of the Professional Practice Evaluation process are privileged and confidential to the full extent authorized by Virginia Code § 8.01-581.17 and are also exempted from production under Section 2.2-3705.1(1) of the Virginia Freedom of Information Act.

a. Members of the Credentials Committee and the PPES will sign an acknowledgment of the requirements for maintaining the privilege at the time of their appointment and yearly thereafter.

b. The Medical Center and the clinical departments shall keep in a secure location provider-specific professional practice information that includes (i) performance data for all benchmarked data; (ii) the results of FPPE and OPPE processes; (iii) the practitioner’s role in sentinel events; (iv) correspondence to the practitioner regarding practice, performance or corrective action.
c. The Credentials Committee and PPES shall determine who shall have access to provider specific practice evaluation information.

SIGNATURES:

DATE:

Medical Center Policy No. 0279 (R)
Approved December 2007
Revised December 2008; December 2010
Approved by Credentials Committee
Approved by Clinical Staff Executive Committee
Attachment E
Report Submission to NPDB

The Health Care Quality Improvement Act of 1986 created the National Practitioner Data Bank, an information clearinghouse, to collect and release certain information related to the professional competence and conduct of physicians, dentists and some other health care practitioners. The statute and its implementing regulations at 45 CFR Part 60 require hospitals and other health care entities to make certain queries and reports to the National Practitioner Data Bank (“NPDB”). The query and reporting requirements are more fully explained and discussed in the National Practitioner Data Bank Guidebook (“NPDB Guidebook”) (2001). The University of Virginia Medical Center, Clinical Staff Office and Credentials Committee comply with the requirements of the federal statute and regulations and the guidance provide by the NPDB Guidebook.

The Clinical Staff office shall query the NPDB when screening physician and dentist applicants for appointment to the Clinical Staff and when considering initial requests to grant, add to or expand clinical privileges. Additionally, the Clinical Staff Office shall query the NPDB at least every two years for each physician and dentist member of the Clinical Staff who holds clinical privileges. Information on professional review actions, licensure actions and medical malpractice payments that is obtained from such queries shall be presented to the Credentials Committee. That Committee shall review and evaluate the information and take such action as is appropriate.

For purposes of reporting to the NPDB, an adverse action taken against a physician or dentist’s clinical privileges includes restricting, suspending, revoking or denying privileges, as well as decisions not to renew a physician or dentist’s privileges if that decision was based on the practitioner’s professional competence or professional conduct. Actions involving a letter of admonition or reprimand, or a warning, are not adverse actions which must be reported to the NPDB.

The Clinical Staff Office shall report to the NPDB the following events:

<table>
<thead>
<tr>
<th>Actions</th>
<th>Time for Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period longer than 30 days</td>
<td>15 days</td>
</tr>
<tr>
<td>Voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation</td>
<td>15 days</td>
</tr>
<tr>
<td>Acceptance of a physician’s or dentist’s surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or reportable professional review action.</td>
<td>15 days</td>
</tr>
<tr>
<td>Summary suspensions that are in effect for more than 30 days, based on the professional competence or professional conduct of the practitioner that adversely affects, or could adversely affect, the health or welfare of a patient is the result of a professional review action taken in accordance with Article 7.4 of the Bylaws of the Clinical Staff.</td>
<td>15 days</td>
</tr>
</tbody>
</table>
Copies of reports to the NPDB shall be sent to the Virginia Board of Medicine and to other jurisdictions in which the practitioner is licensed.

To encourage and support professional review activity of physicians and dentists, federal law provides immunity when professional review responsibilities are conducted: (a) with the reasonable belief of furthering quality health care; (b) after a reasonable effort to obtain the facts of the matter; (c) after the adequate notice and hearing procedures are afforded to the physician and dentist or after such other procedures as are fair under the circumstances, and (d) in the reasonable belief that such action was warranted by the facts known, after such reasonable effort to obtain facts and after meeting notice and hearing requirements in the Bylaws of the Clinical Staff.
MEDICAL CENTER POLICY NO. 0255

4. SUBJECT: Mandatory Reporting of Healthcare Practitioners

5. EFFECTIVE DATE: October 1, 2010 (R)

C. POLICY:

Virginia laws \(^1\) require hospitals and healthcare practitioners to report specific matters related to licensed or certified healthcare practitioners to the Virginia Department of Health Professions. Failure to make the mandatory reports is punishable by fines and licensing penalties. The individuals specified below and all healthcare practitioners providing treatment and care at the Medical Center shall comply with the mandatory requirements for reporting to the Virginia Department of Health Professions.

D. PROCEDURE:

1. The attached charts summarize the reporting requirements contained in Virginia law. All individuals specified in this Policy and all licensed or certified healthcare practitioners providing care and treatment at the Medical Center shall be aware of these mandatory reporting requirements. The meaning of the term “unprofessional conduct”, used in the requirements below, is specified by Virginia laws that contain varying definitions for different professions \(^2\). Any person who needs assistance in understanding the meaning of this term, as applied to a specific circumstance, may contact the Office of General Counsel.

2. For licensed or certified healthcare practitioners who are not GME Trainees and not members of the Clinical Staff, the information listed below shall be provided to the Medical Center’s Chief Nursing Officer, Associate Chief of Clinical Ancillary Services or Chief Ambulatory Services Officer, as appropriate for the specific practitioner:

\(^1\) See, Virginia Code Sections 54.1-2400.6, 54.1-2400.7, and 54.1-2909.
\(^2\) See, e.g. Virginia Code Sections 54.1-2915 and 85-20-25 et seq.,
a. The Office of Human Resources shall provide information of any disciplinary action, including but not limited to: (i) denial or termination of employment for any reason related to intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (ii) professional ethics, (iii) professional incompetence, (iv) mental or physical impairment, (v) moral turpitude or (vi) substance abuse;

b. The Clinical Staff Office shall provide information of any disciplinary action, including but not limited to: (i) denial or termination of employment, (ii) denial or termination of clinical privileges, restriction of clinical privileges, (iii) voluntary restriction or expiration of clinical privileges while the practitioner is under investigation or disciplinary actions are pending for any reason related to intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (iv) professional incompetence, (v) unprofessional conduct, (vi) mental or physical impairment, (vii) moral turpitude or (viii) substance abuse;

c. The manager or director of any unit, Department, clinic or other setting in which the practitioner provides services shall provide any information that indicates that the practitioner has engaged in unethical, fraudulent or unprofessional conduct;

d. The Office of Quality and Performance Improvement and the Office of Patient Safety and Risk Management shall provide any information that indicates that the practitioner has engaged in unethical, fraudulent or unprofessional conduct;

e. The Office of Corporate Compliance and Privacy shall provide any information that indicates that the practitioner has violated federal or state laws or Medical Center Policies applicable to access to and disclosure of personal health information or that the practitioner has engaged in unethical, fraudulent or unprofessional conduct;

f. Any individual who works within the Medical Center or at any other setting under the authority of the Medical Center shall immediately provide any information indicating that a practitioner is a danger to self, patients or the public and is in need of treatment for illness or substance abuse, and

g. Requirements of Item 5 below, as applicable, must be followed.

3. For all members of the Clinical Staff 3, the information listed below shall be provided to the President of the Clinical Staff or the Chief Medical Officer.

a. The Clinical Staff Office shall provide information of any disciplinary action, including but not limited to: (i) denial or termination of employment, (ii) denial or termination of clinical privileges, restriction of clinical privileges, (iii) voluntary restriction or expiration of clinical privileges while the practitioner is under investigation or disciplinary actions are pending for any reason related to intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (iv) professional incompetence, (v) unprofessional conduct, (vi) mental or physical impairment, (vii) moral turpitude or (viii) substance abuse;

3 “Clinical Staff” means those physicians, dentists, podiatrists, and Ph.D. Clinical Psychologists who have been granted clinical privileges.
b. The Chair of any clinical department in which the Clinical Staff Member provides services and the manager or director of any unit, Department, clinic or other setting in which the Clinical Staff Member provides services shall provide any information that indicates that the practitioner has engaged in unethical, fraudulent or unprofessional conduct;

c. The Office of Quality and Performance Improvement and Office of Patient Safety and Risk Management shall provide any information that indicates that the Clinical Staff Member has engaged in unethical, fraudulent or unprofessional conduct;

d. The Office of Corporate Compliance and Privacy shall provide any information that indicates that the practitioner has violated federal or state laws or Medical Center Policies applicable to access to and disclosure of personal health information or that the practitioner has engaged in unethical, fraudulent or unprofessional conduct;

e. Any individual who works within the Medical Center or at any other setting under the authority of the Medical Center shall immediately provide any information indicating that the Clinical Staff Member is a danger to self, patients or the public and is in need of treatment for illness or substance abuse; and

f. Requirements of Item 5, below, must be followed.

4. For GME Trainees, the information listed below shall be provided to the Associate Dean for Graduate Medical Education:

a. The GME Office shall provide information about any disciplinary action, including but not limited to: (i) denial or termination of employment, (ii) denial or termination of clinical privileges, (iii) restriction of clinical privileges, (iv) voluntary restriction or expiration of clinical privileges while the GME Trainee is under investigation or disciplinary actions are pending for any reason related to intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (v) professional incompetence, (vi) unprofessional conduct, (vii) mental or physical impairment, (viii) moral turpitude or (ix) substance abuse;

b. The Chair of any clinical department in which the GME Trainee provides services and the administrator of any unit, Department, clinic or other setting in which the GME Trainee provides services shall provide any information that indicates that the GME Trainee has engaged in unethical, fraudulent or unprofessional conduct;

c. The Clinical Staff Office shall provide information of any disciplinary action, including but not limited to: (i) denial or termination of employment, (ii) denial or termination of clinical privileges, restriction of clinical privileges, (iii) voluntary restriction or expiration of clinical privileges while the practitioner is under investigation or disciplinary actions are pending for any reason related to intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (iv) professional incompetence, (v) unprofessional conduct, (vi) mental or physical impairment, (vii) moral turpitude or (viii) substance abuse;
(SUBJECT: Mandatory Reporting of Healthcare Practitioners)

d. The Office of Quality and Performance Improvement and Office of Patient Safety and Risk Management shall provide any information that indicates that the GME Trainee has engaged in unethical, fraudulent or unprofessional conduct;

e. The Office of Corporate Compliance and Privacy shall provide any information that indicates that the practitioner has violated federal or state laws or Medical Center Policies applicable to access to and disclosure of personal health information or that the GME Trainee has engaged in unethical, fraudulent or unprofessional conduct;

f. Any individual who works within the Medical Center or at any other setting under the authority of the Medical Center shall immediately provide any information indicating that the GME Trainee is a danger to self, patients or the public and is in need of treatment for illness or substance abuse; and

g. Requirements of Item 5, below, must be followed.

5. For all doctors of medicine and osteopathy including GME Trainees, podiatrists, physician assistants, radiological technicians, respiratory care providers, occupational therapists, polysomnographic technologists and nurse practitioners, the information listed below shall be provided to the President of the Clinical Staff, the Chief Medical Officer, or the Associate Vice President for Hospital and Clinics Operations, as appropriate for the specific practitioner:

a. Any individual who works within the Medical Center or at any other setting under the authority of the Medical Center shall provide information indicating that the practitioner (i) is or may be professionally incompetent, (ii) has engaged in intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (iii) has engaged in unprofessional conduct or (iv) may be physically or mentally unable to engage safely in the practice of his profession;

b. Any individual, including the practitioner himself/herself, who works within the Medical Center or at any other setting under the authority of the Medical Center shall provide information of any settlement of a malpractice claim against the practitioner;

c. Any individual, including the practitioner himself/herself, who works within the Medical Center or at any other setting under the authority of the Medical Center shall provide information of any malpractice judgment against the practitioner;

d. Any individual, including the practitioner himself/herself, who works within the Medical Center or at any other setting under the authority of the Medical Center shall provide information of any disciplinary action taken by a licensing board in another state, the voluntarily surrender of a license in another state while under investigation and/or disciplinary action taken by a federal health institution.

6. Notwithstanding the foregoing, any of the information required to be reported hereunder may be reported to the Medical Center’s Office of Corporate Compliance and Privacy. In such event, the Director of that Office shall report the information in accordance with Items 2 - 5 above.
7. The Medical Center's Chief Nursing Office, Associate Chief of Clinical Ancillary Services, Chief Ambulatory Services Officer, Associate Vice President for Hospital and Clinics Operations, the Chief Medical Officer, and the President of the Clinical Staff, as applicable, shall review the information provided and consult with the Chief Executive Officer of the Medical Center, the Office of General Counsel, and others, as necessary, to determine whether reporting to the Virginia Department of Health Professions is required. The practitioner who is the subject of any such report shall be provided a copy of the report when it is submitted to the Department of Health Professions.

SIGNATURE:

DATE:

Medical Center Policy No. 0255 (R)
Approved October 2003
Revised June 2004, June 2007, September 2010
Approved by Credentials Committee
Approved by Clinical Staff Executive Committee

ATTACHMENTS
(SUBJECT: Mandatory Reporting of Healthcare Practitioners)

REPORTING REQUIREMENTS
Virginia Code Section 54.1-2400.6

Who must report: Chief Executive Officer and Chief of Staff of every hospital or health care institution in the Commonwealth.

Penalty for Failure to Report: Civil penalty of up to $25,000 assessed by Director of Department of Health Professions. Loss of Medicare/Medicaid certification and denial of issuance or renewal of license until penalty is paid.
(SUBJECT: Mandatory Reporting of Healthcare Practitioners)

<table>
<thead>
<tr>
<th>Who Is Reported</th>
<th>What Is Reported/Time</th>
<th>To Whom/Content</th>
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<tbody>
<tr>
<td>Any person licensed, certified or registered by a health regulatory board, and Board of Audiology/Speech Audioligists Speech-language pathologists Board of Dentistry Dentists Oral and maxillofacial surgeons Dental hygienists Board of Medicine Doctors of medicine, including interns and residents Doctors of osteopathy Chiropractors Podiatrists Physician Assistants Polysomnographic technicians Radiologic technicians Respiratory care providers Occupational therapists Licensed Acupuncturists Nurse practitioners Licensed athletic trainers Licensed midwives Board of Nursing Registered nurses Licensed practical nurses Nurse practitioners Certified registered nurse anesthetists Clinical nurse specialists Certified nurse aides Certified massage therapists Board of Optometry Optometrists Board of Pharmacy Pharmacists Registered pharmacy technician Board of Physical Therapy Physical therapists Physical therapy assistants Board of Counseling Marriage and family therapists Professional counselors Licensed substance abuse treatment practitioners Certified substance abuse counselors Certified substance abuse counseling assistant Certified rehabilitation providers Board of Psychology Clinical psychologists School psychologists Certified sex offender treatment providers Board of Social Work Clinical social workers Social workers</td>
<td>Any information indicating that practitioner is in need of treatment or has been admitted or committed, to any health care institution, for treatment of psychiatric illness or substance abuse which may render practitioner a danger to self, the public or patients. <strong>Time:</strong> 5 days from when CEO/Chief of Staff learns of admission. 30 days for all others. Any information indicating that there is a reasonable probability that practitioner has engaged in unethical, fraudulent or unprofessional conduct (as defined in applicable law). <strong>Time:</strong> 30 days from when CEO/Chief of Staff learns that reasonable probability exists.</td>
<td>Report in writing to the Director, Virginia Department of Health Professions. Contains name and address of practitioner who is subject of report. Fully describes the circumstances surrounding the facts required to be reported. Report includes names and contact information of individuals with knowledge about the facts required to be reported. Includes names and contact information of individuals from whom health care institution sought information to substantiate facts required to be reported. All relevant medical records attached to report if patient care or practitioner's health status is at issue. Provide notice to Department of Health Professions that, if applicable, report has been sent to National Practitioner Data Bank. Reporting institution shall give practitioner who is subject of report the opportunity to review the report. Practitioner may submit a separate report. Institution is not required to submit any proceedings, minutes, records or reports that are privileged under Va. Code § 8.01-581.17, but that section does not bar required reporting and provision of medical records. Non-waiver: Privilege attached to quality assurance, peer review, credentialing, etc. documents is not waived by this mandatory report. Exemptions: Actual proceedings, minutes, records or reports that are privileged. Records protected by 42 USC 290dd and federal regulations (confidentiality of drug and alcohol abuse treatment records)</td>
</tr>
</tbody>
</table>

**REPORTING REQUIREMENTS**

Virginia Code Section 54.1-2400.7
(SUBJECT: Mandatory Reporting of Healthcare Practitioners)

**Who Must Report:** Every practitioner licensed or certified by a health regulatory board in Virginia or who holds a multistate licensure privilege to practice nursing and who treats professionally any other practitioner licensed or certified by a health regulatory board in Virginia or who holds a multistate licensure privilege to practice nursing.

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<thead>
<tr>
<th>Who Is Reported</th>
<th>What Is Reported</th>
<th>To Whom</th>
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<tbody>
<tr>
<td><strong>Board of Audiology/Speech:</strong></td>
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<tr>
<td>Audiologists</td>
<td>Whenever a practitioner is treated for mental disorders, chemical dependency or alcoholism UNLESS the attending practitioner has determined that there is a reasonable probability that the person being treated is competent to continue in practice or would not constitute a danger to himself or to the health and welfare of his patients or the public.</td>
<td>To the Director of the Department of Health Professions.</td>
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<td>Speech-language pathologists</td>
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<tr>
<td><strong>Board of Dentistry:</strong></td>
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<td>Dentists</td>
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<td>Oral and maxillofacial surgeons</td>
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<tr>
<td>Dental hygienists</td>
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<td><strong>Board of Medicine:</strong></td>
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<td>Board of Medicine:</td>
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<tr>
<td>Doctors of medicine, including interns, residents</td>
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<td>Doctors of osteopathy</td>
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<tr>
<td>Chiropractors</td>
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<td>Podiatrists</td>
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<td>Physician Assistants</td>
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<td>Polysomnographic technicians</td>
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<td>Radiological technicians</td>
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<td>Respiratory care providers</td>
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<td>Occupational therapists</td>
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<td>Licensed Acupuncturists</td>
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<td>Licensed Athletic trainers</td>
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<td>Licensed midwives</td>
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<td><strong>Board of Nursing:</strong></td>
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<td>Registered nurses</td>
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<td>Licensed practical nurses</td>
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<td>Nurse practitioners</td>
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<td>Certified registered nurse anesthetists</td>
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<td>Clinical nurse specialists</td>
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<td>Certified nurse aides</td>
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<td>Massage therapists</td>
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<td><strong>Board of Optometry:</strong></td>
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<td>Optometrists</td>
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<td><strong>Board of Pharmacy:</strong></td>
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<td>Pharmacists</td>
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<td><strong>Board of Physical Therapy:</strong></td>
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<td>Physical therapists</td>
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<td>Physical therapy assistants</td>
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<td><strong>Board of Counseling:</strong></td>
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<td>Marriage and family therapists</td>
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<td>Professional counselors</td>
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<td>Licensed substance abuse treatment practitioners</td>
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<td>Certified substance abuse counselors</td>
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<td>Certified substance abuse counseling assistants</td>
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<td>Certified rehabilitation providers</td>
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<td><strong>Board of Psychology:</strong></td>
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<td>Clinical psychologists</td>
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<td>School psychologists</td>
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<td>Certified sex offender treatment providers</td>
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<td><strong>Board of Social Work:</strong></td>
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<td>Clinical social workers</td>
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<td>Social workers</td>
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REPORTING REQUIREMENTS
Virginia Code Section 54.1-2909

Who Must Report: (1) All practitioners licensed by the Virginia Board of Medicine; (2) All Virginia health care institutions; (3) Presidents of Professional Societies; (4) Malpractice insurance carriers of a person who is the subject of a judgment or settlement; (5) Health Maintenance Organizations.

Penalty for Failure to Report: Civil penalty of up to $5,000 for individuals who are licensed practitioners and unlicensed individuals who fail to report as required by statute. Denial of license or renewal or license until penalty is paid.

<table>
<thead>
<tr>
<th>Who Is Reported</th>
<th>What Is Reported/Time</th>
<th>To Whom/Content</th>
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<tbody>
<tr>
<td>Any person licensed by the Virginia Board of Medicine.</td>
<td>Each of the following must be reported with 30 days:</td>
<td>Report to the Virginia Board of Medicine.</td>
</tr>
<tr>
<td>Doctors of medicine, including interns and residents</td>
<td>Any evidence that indicates a reasonable probability that a person licensed by the Board of Medicine:</td>
<td>Report in writing and shall contain the name and address of the person who is the subject of the report and shall describe the circumstances surrounding the facts required to be reported.</td>
</tr>
<tr>
<td>Doctors of osteopathy</td>
<td>- is or may be professionally incompetent, - - has engaged in intentional or negligent conduct that causes or is likely to cause injury to a patient or patients,</td>
<td>Includes names and contact information of individuals from whom health care institution sought information to substantiate facts required to be reported.</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>- has engaged in unprofessional conduct</td>
<td>Privilege for quality assurance, peer review records, etc. is not waived by the required report.</td>
</tr>
<tr>
<td>Podiatrists</td>
<td>- may be physically or mentally unable to engage safely in the practice of his profession.</td>
<td>Reporting requirements satisfied if matters are reported to the National Practitioner Data Bank, but notice of such report must be provided to the Board of Medicine.</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>Any settlement of a malpractice claim against a person licensed by the Virginia Board of Medicine.</td>
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<tr>
<td>Polysomnographic technicians</td>
<td>Any malpractice judgment against a person licensed by the Virginia Board of Medicine.</td>
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<tr>
<td>Radiological technicians</td>
<td>Disciplinary action taken against a person licensed by the Virginia Board of Medicine in another state, a federal health institution or the voluntary surrender of a license in another state while under investigation.</td>
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<td>Respiratory care providers</td>
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<td>Nurse practitioners</td>
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</table>
Attachment G
Rules and Procedures for Review
of Credentialing/Privileging Files

As outlined in Section IX of this manual, specific individuals are permitted access to the credentials/privileging file only if such review is in furtherance of the Credentials Committee processes.

A verbal or written request must be submitted to the Director of the Clinical Staff Office indicating the reason for such review. If the request is approved, the Director or a member of the Clinical Staff Office will retrieve the requested file(s) and secure a private space for review of the file(s). The Director or Clinical Staff Office member will remain with the credentialing/privileging file(s) at all times.