VERMONT STATE HOSPITAL
Waterbury, Vermont

MEDICAL STAFF BYLAWS

Approved by VSH Governing Body March 2008
Amendments Approved by VSH Governing Body September 2008
Approved in whole by Commissioner of Mental Health January 2009
Amendments Approved by Commissioner of Mental Health June 2009

PREAMBLE

These Bylaws are established in order to provide for the organization of the Medical Staff of Vermont State Hospital (VSH) and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations and organized Medical Staff relations with the Commissioner of Mental Health (Commissioner). These Bylaws, when adopted by the Medical Staff and the Commissioner, create a mutually binding agreement between the Medical Staff and the Commissioner.

ARTICLE I

NAME

1.1 **Name** - The name of this organization shall be the Medical Staff of VSH hereinafter referred to as the Medical Staff.

ARTICLE II

PURPOSES; TRANSITION PROVISIONS

2.1 **Purposes** - The purposes of this organization shall be:

a. To exercise overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the Commissioner.

b. To establish a mechanism to ensure that all individuals with clinical privileges shall have the right to exercise those privileges in a non-discriminatory manner consistent with the mission of VSH, and shall provide services within the scope of individual clinical privileges granted.

c. To continuously improve the quality of patient care through the monitoring and evaluation of the quality and appropriateness of patient care.

d. To develop, adopt, and enforce Bylaws and regulations, which establish a framework for Medical Staff activities and relationship with the Commissioner.

e. To provide a means and structure whereby problems of a medico-administrative nature may be discussed by the Medical Staff with the Commissioner and the Administration.

f. To engage in cooperative efforts with educational institutions in the area, particularly the University of Vermont, in programs of teaching and research.

2.2 **Transition Provisions** –
On the effective date of adoption of these Medical Staff Bylaws, the members of the Medical Staff of VSH shall be comprised of all those persons who are members of the medical staff of VSH. After the effective date, the members of the

Medical Staff shall be subject to reappointment and review in accordance with these Bylaws.

2.3 **Medical Director** - The Executive Director of the VSH shall designate the Medical Director to carry out the duties specified in these Bylaws and all other administrative duties as required by these Bylaws including, but not limited to the following duties:

a. The Medical Director shall direct the development, implementation, organization, and functioning of the Medical Staff credentialing process, oversee quality management initiatives relating to the Medical Staff, participate in utilization review and clinical risk review, for continuous assessment and improvement of performance and ensure compliance with regulatory and accrediting requirements.

b. The Medical Director shall be responsible for the on going surveillance of professional performance of all individuals in the Hospital that have clinical privileges.

c. The Medical Director shall be accountable for the development and implementation of policies and procedures that guide and support the provision of services and clinically related activities of the Medical Staff, including orientation and continuing education.

d. The Medical Director shall work with VSH's administration, nursing, and other patient care support services to coordinate and integrate interdepartmental delivery of services to all clinical units.

e. The Medical Director shall be the Medical Staff leader on Quality Assurance activities necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes.

f. The Medical Director shall oversee a system designed to routinely collect and assess data related to important clinical and non-clinical processes and resulting patient outcomes. Objective criteria and appropriate statistical quality control techniques are utilized in the measurement and assessment processes to identify opportunities to improve patient care and organizational functions.

ARTICLE III

DIVISIONS OF THE MEDICAL STAFF; DELINEATION OF CLINICAL PRIVILEGES

3.1 **Medical Staff Divisions** – The Medical Staff shall be divided into the Active Medical Staff, Part-Time Medical Staff, and Resident Trainee Medical Staff and Associate Medical Staff categories.

Appointment to the Medical Staff confers the privilege to practice within VSH and the use of VSH facilities. Members of the Active and Associate Staff are responsible for supporting the clinical, educational, and research missions of VSH. These responsibilities include teaching, covering patients in emergency situations, providing on-call coverage, and cooperating with research protocols when appropriate.

a. **Active Medical Staff** are physicians who work half-time or more at the VSH. They are full voting members of the Medical Staff and have clinical privileges. The Medical Director is a member of the Active Medical Staff.

b. **Part-Time Medical Staff** are fully trained physicians who work part-time at the VSH and take direct patient care responsibilities. Members in this category may have clinical privileges. They are non-voting members of the Medical Staff.

c. **Resident Trainee Medical Staff** are physicians who are receiving specialty training in psychiatry. These physicians work under the supervision of a fully trained psychiatrist. They are non-voting members of the Medical Staff.

d. **Associate Medical Staff** are those practitioners who require physician collaboration or supervision as defined by Vermont law or are otherwise required to have oversight by a physician as defined by the Medical Staff Bylaws. The Associate Staff shall include, but not be limited to; physician assistants and advance practice registered nurses. Members of the Associate Staff may exercise independent judgment within the scope of their licensure, certification, and/or area of expertise; participate directly in the management of patients under the supervision or direction of a member of the Active or Part-Time staff; record reports and progress notes in the patients' records; write orders and admit patients to the extent established by the Medical Director and in accordance with applicable law. Members of the Associate Staff are not voting members of the Medical Staff.

3.2 **Clinical Privileges.** All members of the medical staff shall be eligible for clinical privileges as demonstrated by their individual education, training, experience and competence, and as recommended by the Medical Director, the Medical Executive Committee (MEC) and approved by the Commissioner. These privileges must be consistent with the objectives and needs of the hospital.

ARTICLE IV

APPOINTMENT TO THE MEDICAL STAFF;

GRANTING OF CLINICAL PRIVILEGES

4.1 **Eligibility Criteria** – Each applicant for Medical Staff membership and clinical privileges, shall commit in writing to the following criteria:

a. Mission - Each applicant must be willing to advance the patient care, teaching and research missions of VSH as set forth in (b) below.

b. Criteria -

i. Criteria for commitment to patient care include:

A. Participation with VSH staff in care of patients;
B. Adhering to the Bylaws and Rules and Regulations regarding records;
C. Adhering to the Code of Ethics of the American Medical Association and the Code of Ethics of the American Psychiatric Association or other professional organization of the applicant, if not a psychiatrist;
D. Adhering to VSH policies and procedures regarding patient care and hospital operations, including the Patient's Bill of Rights;
E. Willingness to be a member of VSH and/or Medical Staff committee.

ii. Criteria for commitment to education include:

A. Willingness to participate in teaching rounds with residents and students
B. Willingness to give lectures to staff, residents, and students
C. Willingness to have residents or medical students participate with the Active Staff in the hospital setting

iii. Criteria for commitment to research includes:

Willingness to encourage hospital patients, subject to the physician's medical and ethical judgment, to be involved in clinical research provided that such research conforms with a duly adopted VSH policy and procedure related to clinical research,

4.2 **Credentials** - Each applicant for Medical Staff membership and clinical privileges shall provide satisfactory evidence of the following credentials to assure the Active Medical Staff and the Commissioner that any patients treated will receive quality care. The application for appointment and privileges provides the means by which the applicant is to supply the following information and evidence of credentials.

a. Current, full, unrestricted license to practice medicine in the State of Vermont;

b. Board eligibility or board certification in one's specialty unless no such designation exists;

c. Current competence, judgment, responsiveness, and a willingness to commit to the mission of VSH and the Bylaws;

d. Professional ethics consistent with the Code of Ethics as adopted by the professional organization of the applicant;

e. Primary source verification of education, training and experience;

f. All Medical Staff members must be insured, at a minimum, for limits of $1 million per claim and $3 million in the aggregate. Insurance coverage must have a retroactive date on or before the initial date of employment by or association with VSH. All Medical Staff shall be insured by companies licensed and admitted in Vermont or on the State's approved "white list" of excess and surplus lines insurers. Captive insurance company policies, or policies issued by companies organized under the Federal Risk Retention Act of 1986 are permitted, subject to the approval of the Risk Management Department. Evidence of renewal coverage must be provided annually to Medical Director;

g. DEA Registration, when applicable, current and up-to-date;

h. Health status commensurate with the requirements of the position;

i. Continuing education credits are required for appointment and reappointment to the Medical Staff. Members are required to submit evidence of a minimum of forty AMA Category I continuing education credits over a two year period; and

j. Such additional credentials or criteria as may be specified by the Rules and Regulations relating to specific clinical privileges.

4.3 **<u>Other considerations</u>** - The following criteria shall also be considered:

a. The ability of VSH to provide adequate facilities and supportive services, including the required supervisory and administrative functions of or by the Medical Staff, for the applicant and his or her patients;

b. The proximity of the applicant and his/her ability to access VSH.

c. The impact of the appointment or the granting of privileges upon the service and educational mission of VSH.

d. Peer recommendation(s);

e. Conduct which evidences unfitness to practice medicine; and

f. Current challenges to any licensure or registration; voluntary or involuntary relinquishment of any license or registration; voluntary or involuntary relinquishment of clinical privileges; voluntary or involuntary termination of Medical Staff membership at any hospital; and any previous or current liability actions.

g. The results of a query to the National Practitioner Data Bank at appointment and reappointment. The NPDB shall also be queried when a member requests new privileges or requests expansion of their current privileges.

h. The results of a criminal history report.

i. **Prohibited bases for discrimination** - Gender, sexual orientation, race, creed, origin, economic, age, marital status, or disability considerations shall not be used in making decisions regarding membership on the Medical Staff or the granting of delineated clinical, privileges, except where disability renders the person incapable, despite reasonable accommodations, of performing the essential functions of the medical staff appointment.

4.4 Application and Review Procedure

a. Application. Each applicant for Medical Staff membership and clinical privileges shall submit to the Medical Director: a signed application requesting appointment; information and evidence to satisfy the criteria, credentials and considerations set forth in Sections **4.1, 4.2 and 4.3** of these bylaws; and, specification of the clinical privileges requested. Upon receipt of a complete application, the name of the applicant will be circulated to the Medical Staff. Members of the Medical Staff that wish to provide information about the applicant shall contact the Medical Director. The applicant must consent to an inspection of all records and documents pertinent to his/her application, a criminal record check, a search of the NPDB, a search of the Adult Protective Services records, and to appear for an interview if requested. It shall be the applicant's responsibility and burden of proof to provide information to support their request for appointment and clinical privileges and to resolve any doubts that arise during the review of their application.

b. An application will be deemed "complete" when all documentation has been provided / obtained and all information has been verified. The completed

application will immediately be forwarded to the Active Medical Staff for review.

c. Review by Active Medical Staff. The Active Medical Staff will review the application for appointment to the Medical Staff and will, within 15 days, make its recommendation regarding appointment and privileges to the Medical Director and Executive Director for approval. The Medical Staff will base its recommendation on the applicant's verified credentials and consideration of the applicant's character, demonstrated competence, training and experience including consistency with the criteria, credentials and considerations set forth in Sections **4.1, 4.2 and 4.3** .

d. Review by Medical Director and Executive Director. The Medical Director and the Executive Director will review the application for appointment and privileges to the Medical Staff and will, within 15 days, make its recommendation to the Commissioner for approval. Any recommendation will be based on the applicant's verified credentials and consideration of the applicant's character, demonstrated competence, training and experience including consistency with the criteria, credentials and considerations set forth in Sections **4.1, 4.2 and 4.3**.

e.. Action by the Commissioner. The Commissioner shall review and take action on each application at its next regular meeting following receipt of the recommendations of the Medical Director and Executive Director. The Commissioner shall have the authority to accept or reject the recommendations or may return the application to the Medical Staff, Medical Director and Executive Director for further consideration stating the reasons for such action. If the Commissioner approves an application without any limitation, such vote shall be reflected in the minutes. If the Commissioner proposes to take any action to reduce, restrict, suspend, revoke, deny or fail to renew clinical privileges and/or membership in the Medical Staff, such action shall not become final until the Commissioner shall first give the applicant written notice of the action to be taken, stating the reasons for the proposed action, stating that the applicant has thirty (30) days from the date of receipt of the Commissioner's notice to request a hearing, and providing a summary of the applicant's rights in the hearing under Article XI of these Bylaws.

f. Time Frame. The above process shall be completed, whenever possible, within 60 days after receipt of the Medical Staff recommendation.

4.5 Term of Appointment.

Initial Appointments. All initial appointments to the Medical Staff and granting of clinical privileges shall be provisional for a term of one (1) year after approval by the Executive Director and the Commissioner. During the provisional term the performance of the provisional appointee shall be

evaluated by the Medical Director. Based upon such evaluation and within the guidelines of the rules and regulations, at the end of the provisional term, the Medical Director shall issue a recommendation to the Executive Director to: (A) convert the provisional appointment to a regular appointment to the Medical Staff for a period (provisional appointment and regular appointment combined) not to exceed two (2) years; (B) extend the provisional period for only one (1) additional term of one (1) year; or (C) deny appointment. Any decision by the Executive Director and approved by the Commissioner to deny the provisional appointee an appointment to the Medical Staff may be appealed by the individual as provided for in Article XI of these Bylaws.

Regular Appointments. Regular appointments to the Medical Staff and granting of clinical privileges shall be for a term not to exceed two (2) years.

4.6 Temporary/ Interim Appointment to Medical Staff.

Temporary appointment to the Medical Staff and clinical privileges may be granted under the following circumstances:

i. To fulfill an important patient care, treatment, and service need;

ii. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Commissioner.

iii. All temporary privileges shall be granted by the Executive Director or authorized designee, providing the applicant has been reviewed and recommended for approval by the Medical Staff and the Medical Director.

iv. Temporary privileges may be granted for no more than 60 days.

vi. An individual with temporary privileges shall have no right to vote.

4.7 Emergency Care

In the case of an emergency, any individual who is a member of the Medical Staff with delineated clinical privileges is permitted to do everything possible, within the scope of the individual's license, to save a patient's life or to save a patient from serious harm, regardless of the individual's staff status or clinical privileges.

4.8 Leaves of Absence (LOA)

A member of the Medical Staff who will be absent for a period of at least four (4) months shall submit an application for a leave of absence to the Medical Director. An individual on an authorized leave of absence is subject to the

Bylaws, Rules and Regulations of the Medical Staff, including the requirements for maintenance of a current license, continuous liability insurance coverage, if engaged in clinical practice at VSH during the LOA, or continuous coverage or evidence of tail coverage, if not engaged in clinical practice at VSH during the LOA, and the payment of dues. The individual will be exempt from attending regular meetings of the service and the staff. VSH may implement any of the following options in regard to LOAs:

i. Reappoint the member prior to the start of the LOA;
ii. Allow the member's appointment to lapse and upon the member's return from the LOA, implement the process to grant temporary privileges to new applicants;
iii. Reappoint the member during the LOA based on information gathered to date, on the condition that the member submits evidence of his/her ability to perform the privileges granted on their return from the LOA.
iv. In order to return from an LOA, the Medical Staff member must submit to the Medical Director an application to return to active status. Failure to submit an application to return at the completion of the LOA will constitute a voluntary relinquishment of appointment and privileges.

4.9 Conflict of Interest

Under no circumstances may a member of the VSH medical staff place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

a) Medical staff members must conduct themselves and their affairs so as to avoid or minimize conflicts of interest, and must respond appropriately when conflicts arise.

b) The following are representative, but not inclusive, of conflict of interest situations:

   i) Influence on purchases of equipment, instruments, materials or services for the hospital from a private firm in which the medical staff member, or an immediate family member, has a financial interest;

   ii) Unauthorized disclosure of patient or VSH information for personal gain;

   iii) Giving, offering, or promising anything of value, as a representative of VSH, to any government official to enhance relations with that official or government agency;

   iv) Transmission to a private firm or other use for personal gain of VSH supported work, products, results, materials, record, or information that are not made generally available;

v) Influence upon the negotiation of contracts between VSH and private organizations with which the medical staff member, or immediate family members, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence;

vi) Improper use of institutional resources for personal gain;

vii) Acceptance of compensation or free services from a vendor, service provider, or contractor of VSH, when the medical staff member is in a position to determine or influence VSH's purchases from those persons.

c) **Disclosure**.

i) Whenever a medical staff member is in a situation where he/she may be potentially in a conflict of interest situation, that member should make a full disclosure in writing of the details of the situation to request an exception. This disclosure should be submitted to the Medical Director. The Medical Director shall make any necessary disclosures to the Executive Director.

ii) The Medical Director shall the review the situation and examine all facts thoroughly for apparent conflicts. If the Medical Director determines that VSH would be best served by the granting of the exception, he/she may do so in writing with justification for the granting and delineating of any conditions placed on the approval. If the Medical Director determines that no exception should be granted, that is a final determination and there is no appeal from that decision. If the Medical Director determines that there has been a violation of this policy he/she may meet with the medical staff member to agree upon appropriate resolution of the conflict and/or may institute disciplinary action under these Bylaws.

d) **Reporting.**

i) Suspected conflicts of interest should be reported to the Medical Director. Such reports may be made confidentially, and even anonymously, although the more information given the easier it is to investigate the reports. Raising such concerns will not jeopardize anyone's employment or medical staff membership.

ii) All violations of laws or regulations should be reported to the Executive Director or Commissioner. Violations will result in the taking of appropriate disciplinary action up to and including termination of medical staff membership. Disciplinary action will be taken in accordance with these Bylaws.

(Section 4.9 added June 17, 2009)

4.10 Disaster Privileges to Volunteer Licensed Independent Practitioners

a) Licensed independent practitioners who are not members of the VSH medical staff and who do not already possess clinical privileges to practice at VSH, may

be granted volunteer disaster privileges while the hospital's Emergency Disaster Plan is in effect, and the hospital is unable to handle the immediate patient needs. The Executive Director, Medical Director or his/her designee(s) **may** grant disaster privileges and such decision(s) to grant privileges shall be made on a case-by-case basis.

b) **Procedure for Granting Disaster Privileges**

i) **Identification.** The Executive Director, Medical Director, or his/her designee(s) may grant disaster volunteer privileges to practitioners upon the presentation of a valid government-issued photo identification issued by a state or federal agency (e.g. driver's license or passport) AND at least one of the following:

A) Current license to practice medicine in the State of Vermont, OR

B) Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster; OR

C) Primary source verification of the license; OR

D) Current hospital picture identification card from a Vermont hospital that clearly identifies professional designation; OR

E) Picture identification which indicates that the individual is a member of a Disaster Medical Assistance Team or Medical Reserve Corp, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; OR

F) Picture identification which indicates that the individual has been granted authority by a government entity to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.

ii) **Badge.** If resources are available to make badges, provide the practitioner a VSH photo ID Badge. The practitioner's current photo ID *or* current photo ID badge may be modified for use as a temporary VSH ID badge if resources are not available to produce an *original* VSH photo ID Badge.

iii) **Verification**. The verification process is a high priority. VSH Executive staff shall begin the verification process of the credentials and privileges of individuals who receive volunteer disaster privileges as soon as the immediate situation is under control, and shall complete the process within 72 hours from the time the volunteer practitioner presents to VSH.

A) The verification process shall including the following: Primary source verification of licensure, malpractice insurance coverage and hospital affiliation(s) shall be done as soon as feasible. The National Practitioner Data Bank (NPDB) and Office of the Inspector General (OIG) will also be queried. A written record of this information and verification(s) shall be retained in the volunteer practitioner's file.

B) When emergency verifications are complete the Executive Director, Medical Director, or designee(s) will be notified.

C) The Executive Director, Medical Director, or designee(s) makes a decision within 72 hours related to the continuation of the disaster privileges initially granted based on information obtained regarding the professional practice of the volunteer.

D) In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g. no means of communication or lack of resources), it is expected that it will be accomplished as soon as possible. In this extraordinary circumstance, documentation will include the following:

(1) Why primary source verification could not be performed in the required time frame

(2) Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services

(3) An attempt to rectify the situation as soon as possible.

E) Primary source verification of licensure will not be required if the volunteer practitioner has not provided care, treatment, and services under the volunteer disaster privileges.

c) **Conditions of Disaster Privileges**

i) **Supervision.** The practitioner granted disaster privileges shall practice under the direction and supervision of an existing member of the Medical Staff.

ii) **Monitoring.** The professional performance of the volunteer practitioner granted disaster privileges will be monitored be either direct observation, mentoring and/or clinical record review.

iii) **Attestation.** The practitioner granted disaster privileges shall, by signed statement:

A) Attest that all information provided by him/her is true and accurate.

B) Be bound by all hospital policies and procedures, and the Medical Staff Bylaws, and any directives from the Medical Director, supervising physician or any other hospital or medical staff leader.

C) Agree to defend, indemnify and hold harmless The State of Vermont for all acts and omissions.

d) **Termination of Disaster Privileges**

i) Disaster privileges will terminate when one of the following occurs::

A) In the event any information is received that suggests the practitioner is not capable of rendering services in an emergency; or

B) When the practitioner’s services are no longer needed; or

C) When the VSH Emergency Disaster Plan is inactivated.

(Section 4.10 added June 17, 2009)

ARTICLE V

REAPPOINTMENT TO MEDICAL STAFF;

RENEWAL OF CLINICAL PRIVILEGES

5.1 Criteria –

a. Reappointment to the Medical Staff and renewal of clinical privileges shall be based upon the eligibility criteria set forth in section 4.1, 4.2 and 4.3 and a reappraisal of the applicant at the time of such reappointment or renewal, which shall include information concerning the applicant's current licensure, board certification status, health status, professional performance, judgment, clinical and technical skills, as indicated by the results of quality assurance activities and other reasonable indicators of continuing qualifications.

b. Peer recommendations shall be part of the basis for the development of recommendations and decisions concerning reappointment to the Medical Staff or renewal of clinical privileges or scope of practice.

c. Consideration shall be given to current challenges, voluntary, or involuntary relinquishment of any licensure or registration; voluntary or involuntary termination of Medical Staff membership at any hospital or health care organization; and any previous or current liability actions.

d. Medical Staff shall develop and utilize processes for monitoring clinical performance of staff.

e. A member of the Medical Staff or an individual with clinical privileges or scope of practice who leaves the geographic area without an authorized leave of absence will not be eligible for reappointment to the Medical Staff or renewal of clinical privileges. If a physician on an authorized LOA is due for reappointment while they are on LOA, they will be required to complete the reappointment process. Failure to submit an application will constitute a voluntary relinquishment of privileges.

f. **Board Certification** - Board Certification must be sought if board eligible or maintained if board certified as required by the applicant's specialty and/or subspecialty board. Current Medical Staff members who were previously certified, may extend the time limit for up to one (1) year for achieving the board recertification requirements. Any extension of time must be approved by the Medical Director.

5.2 <u>Procedure</u>

a. <u>Application</u> - Each applicant for reappointment and renewal of clinical privileges shall submit an application for reappointment, including information sufficient to satisfy the criteria set forth in Section 5.1. The application for reappointment provides the means by which the applicant is to supply the information and evidence of credentials. The applicant must consent to an inspection of all records and documents pertinent to his/her application for Medical Staff membership and clinical privileges and to appear for an interview, if requested.

b. Review and Action - Each application for reappointment and renewal of clinical privileges shall be submitted and reviewed, with recommendations by the Medical Staff and Medical Director and action by the VSH Executive Director and Commissioner, as provided by these Bylaws for applications for initial appointment and reappointment to the Medical Staff.

ARTICLE VI

TERMINATION, SUSPENSION, OR RESTRICTION OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGES

6.1 Authority - The exercise of clinical privileges at VSH shall be subject to the rules and regulations of VSH and to the authority of the Medical Director as specified by these Bylaws.

6.2 Summary Suspension or Restriction of Privileges

a. Criteria for Initiation

Whenever a member's conduct requires that immediate action should be taken to protect the life, health, safety, or well-being of any person, or where there is evidence that the exercise of clinical privileges by the member may substantially and adversely affect the quality of patient care, the member's Medical Staff membership and clinical privileges may be summarily suspended or restricted. A summary suspension or restriction requires approval by the Medical Director and the Executive Director.

The suspension or restriction shall take effect immediately upon written notice to the member. The Medical Director and the Executive Director shall promptly provide a copy of such notice for review to all members of the Medical Staff and to the Commissioner of Mental Health.

Unless otherwise indicated by the terms of the summary suspension or restriction, the member's patients shall be assigned to another member by the Medical Staff, considering, where feasible, the wishes of the patient in the selection of a substitute member.

b. Review Procedure

Within 48 hours of such suspension or restriction, excluding weekends or holidays, there shall be a meeting of the affected physician, the Medical Director and the Executive Director to review the action taken. If the suspension or restriction is not terminated at this meeting, the Medical Staff shall review the summary suspension or restriction within ten (10) calendar days after the summary suspension or restriction was imposed. The member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Staff may impose. In no event shall any meeting of the

Medical Staff, with or without the member, constitute a "hearing" within the meaning of Article XI. The procedural rules stipulated in Article XI shall not apply. The Medical Staff may recommend to the Medical Director to modify, continue, or terminate the summary suspension or restriction. The Medical Director shall furnish the member with notice of his decision.

If the Medical Director continues the summary suspension or restriction, the member shall be entitled to the procedural rights afforded by Article XI.

c. State Reporting Requirement
Pursuant to Vermont law (26 V.S.A. § 1317 (a)) all summary suspensions or restrictions shall be reported to the Vermont Commissioner of Health within ten (10) days of the date such summary suspension or restriction was imposed.

6.3 **Suspension, Restriction and Termination with Notice** - Except as provided in subparagraph 2 of this article, Medical Staff membership and clinical privileges shall not be suspended, restricted, or terminated without prior notice to the affected individual and an opportunity to be heard in accordance with the procedures for reappointment and renewal of privileges set forth in Article V of these Bylaws.

6.4 **Notification to National Practitioner Data Bank and the Medical Board** – VSH follows State and Federal mandates and guidelines required for reporting unprofessional conduct, including any disciplinary action taken against any physician, to the National Practitioner Data Bank and the Vermont Medical Practice Board.

6.5 **Automatic Revocation, Suspension, or Restriction of Medical Staff Membership/Clinical Privileges**

In the following instances, the member's privileges or membership shall be revoked, suspended or limited as described below, which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred:

a. License
Revocation and Relinquishment: Whenever a member's license or other legal credential authorizing practice in the state of Vermont is revoked or relinquished, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

Suspension: Whenever a member's license or other legal credential authorizing practice in the state of Vermont is suspended, Medical Staff membership and clinical privileges shall be automatically suspended as of the date such action becomes effective.

Limitation and Restriction: Whenever a member's license or other legal credential authorizing practice in the State of Vermont is limited or restricted, any clinical privileges which the member has been granted at VSH which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

Probation: Whenever a member is placed on probation by the applicable licensing authority, the member's status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

b. Controlled Substances

Revocation, Limitation, and Suspension: Whenever a member's DEA certificate or other legal credential authorizing the member to prescribe medications is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications, covered by the certificate or other legal credential, as of the date such action becomes effective and throughout its term.

Probation: Whenever a member's DEA certificate or other legal credential authorizing the member to prescribe medications is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of probation, as of the date such action becomes effective and throughout its term.

The Medical Director shall be responsible for developing an action plan to ensure continuity of care and patient safety. Said action plan shall go into effect when approved by the Medical Staff at its next regularly scheduled meeting. Members who do not have a valid DEA certificate shall be prohibited from supervising residents who will be writing for controlled substances.

c. Federal Health Care Programs

Debarment and Exclusion: Whenever a member has been debarred or excluded from participation in Medicare, Medicaid, or any other Federal Health Care Program, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

Suspension: Whenever a member has been suspended from participation in Medicare, Medicaid, or any other Federal Health Care Program, the member shall automatically and correspondingly be divested of the right

to render, order, or prescribe items or services that are paid in whole or part, directly or indirectly, by Federal Health Care Programs.

d. Medical Records

Review of privileges will occur upon recommendation of the Medical Director pursuant to inadequate medical record completion.

e. Continuing Privilege Deliberations

All automatic suspensions or restrictions of privileges as described in Section 6.5 shall be reported to the Medical Director in a timely manner. The Medical Director shall review and consider the facts and may initiate such further corrective action as may be deemed appropriate following the procedure set forth commencing at Section 6.2.

f. Reappointment/Reinstatement to Medical Staff; Reinstatement of Clinical Privileges

Individuals who have been subject to any of the actions described in Sections 6.5 (a), (b), and (c) who wish to be re-appointed or reinstated to the Medical Staff and have their clinical privileges reinstated shall provide satisfactory evidence that the legal/regulatory action that resulted in the revocation, suspension, or restriction of their membership or clinical privileges has been modified, lifted, or overturned. Requests for reappointment or reinstatement to the Medical Staff and reinstatement of clinical privileges shall be evaluated and processed in accordance with the procedure set forth in Article V.

If the member's license or other legal credential authorizing practice in the state of Vermont is suspended for administrative reasons unrelated to the member's qualifications and/or competency (i.e., suspension due to failure to renew license on a timely basis) the member shall be automatically reinstated to the Medical Staff on the date the member is granted a license or other legal credential by the state of Vermont.

If the member's DEA certificate or other legal credential authorizing the member to prescribe medications is suspended for administrative reasons unrelated to the member's qualifications and/or competency (i.e., suspension due to failure to renew certificate on a timely basis) the member's right to prescribe medications shall be automatically reinstated on the date when the member is granted a DEA certificate or other legal credential authorizing the member to prescribe medications.

ARTICLE VII

PHYSICIAN HEALTH

7.1 Self-Referral and Referral by Other Organization Staff

Impaired physicians are encouraged to self-report. Self reported problems such as substance abuse and mental illness are handled confidentially. Confidentiality is minimal if patient harm has occurred because of the suspected impairment or if the individual has been disciplined previously by the hospital or by the licensing authority.

Other organization staff must report questions regarding competence or impairment to their supervisor who then reports to the Medical Director. Issues requiring corrective and/or disciplinary action will be handled in accordance with Article VI of these bylaws.

7.2 Referral to Appropriate Resources for Diagnosis and Treatment

The hospital administration will assist, as needed, a physician who has been identified as impaired in finding internal or external resources for diagnosis and treatment of the condition or concern.

7.3 Maintenance of Confidentiality

The confidentiality of a physician seeking referral or referred for assistance is maintained except as limited by law, ethical obligation, or when the safety of a patient is threatened.

7.4 Evaluation of Credibility of Complaint, Allegation, or Concern

Anonymous complaints are dismissed. An investigation of other complaints and interview of involved persons and witnesses is carried out by the Credentials Committee. Results are reported to the Medical Director and Executive Director. An administrative decision is made as to whether there is credibility. If a complaint may have merit, it is reported to the Board of Medical Practice.

7.5 Education about illness and impairment

Medical staff and other hospital staff shall receive competency-based training, annually, regarding illness and impairment recognition issues specific to physicians.

ARTICLE VIII

CLINICAL PRIVILEGES FOR EDUCATIONAL NEED

8.1 Visiting Practitioner Privileges for Educational Need

A licensed independent practitioner who is not an applicant for membership but who will be performing medical procedures as a part of course of instruction at VSH may be granted privileges for a period not to exceed two years.

Credentials - Each applicant shall provide satisfactory evidence of the following credentials to the Medical Staff Office:

a. The licensed independent practitioner is to provide a current CV or a copy of their medical staff application at a JCAHO accredited hospital completed within the past six (6) months, State of Vermont license, and a signed consent and release form.
b. Minimum of $1/$3 million malpractice insurance coverage that covers practitioner in the State of Vermont.
c. One (1) letter of reference from the practitioner’s department chair, medical director, vice president of medical affairs, or an individual with knowledge of the applicant's clinical competence and status at their home accredited institution.
d. The appropriate form completed by the sponsoring physician and the applicant requesting and delineating the purpose of the visit, scope of practice, and a list of the supervising staff members.
e. Disclosure of any financial arrangements or potential conflicts of interest concerning this relationship.

Practitioner is to be credentialed, which includes a query to the National Practitioner Data Bank, American Medical Association, the Federation of State Medical Boards and/or applicable state licensing agency(ies).

The completed application will be reviewed and recommendations made by the Medical Director, and final approval subject to action by the Executive Director and the Commissioner.

Article IX

RESEARCH PRACTITIONERS

9.1 Eligibility – Practitioners whose activities are restricted to clinical research activities at VSH shall be eligible for appointment as a Research Practitioner.

Research Practitioner’s Scope of Practice shall be limited to those activities assigned or delegated to the Research Practitioner pursuant to research protocols approved by the AHS and FAHC Institutional Review Boards (IRB) consistent with a duly adopted VSH research policy and procedure.

9.2 **Review of Application** – Applications shall be submitted to the Medical Director, and shall be processed and reviewed in the same manner as provided in Section 4.2 (b) of these Bylaws.

9.3 **Membership on the Medical Staff** – The granting of authorization to a Research Physician to engage in research-related activities shall not confer the rights or privileges of membership on the Medical Staff.

9.4 **Termination** – Any granting of authorization to a Research Physician to engage in research-related activities may be terminated by the Medical Director upon written notice to the Research Physician.

9.5 **Reappointment** – Research Physicians shall complete the reappointment process as defined in Article V of these Bylaws. A recommendation from the Medical Director must be submitted to the Executive Director for reappointment.

ARTICLE X

ALLIED HEALTH CARE PROFESSIONALS

10.1 **Eligibility** - An Allied Health Care Professional (AHP) who is not licensed to practice independently in a hospital, but is otherwise qualified to provide a needed and beneficial service to patients in the hospital under the direct supervision of a member of the Active Medical Staff, shall be eligible for appointment as an AHP subject to the provisions of this Article.

The Allied Health Care Professional shall provide evaluation and care to only those patients of his/her supervising physician(s). The supervising physician shall see all patients cared for by the Allied Health Care Professional within twenty-four (24) hours of initial evaluation**.**

10.2 **Classifications, Qualifications, Responsibilities**

a. Upon the written request of any member of the Active Staff directed to the Medical Director, and upon the favorable recommendation of the Medical Director to the VSH Executive Director, one or more AHP classifications may be established in which an AHP shall be eligible to receive authorization to provide specific health care services to patients in VSH under the supervision of a member of the Active Staff (the "supervising physician").

b. Establishment of an AHP classification shall be based in each case upon consideration of (i) the need for the clinical services to be provided by an AHP within that classification and (ii) the benefit of those services to patients of the VSH.

c. Prior to the establishment of an AHP classification, the Executive Committee shall direct the preparation and publication of a description of the qualifications and scope of practice for that classification, which shall be approved by the Medical Staff, and shall set forth the specific health care services which may be authorized for an AHP, the related responsibilities which must be assumed by the AHP upon the granting of such authorization, and the minimum qualifications necessary to obtain authorization within that AHP classification. In determining the appropriate health care services, responsibilities and qualifications for an AHP classification, consideration shall be given to any existing national, state or customary professional standards of practice for that AHP classification. Authorization shall not be granted to an AHP for health care services or responsibilities which are inconsistent with state licensure or practice requirements or with other applicable provisions of law.

10.3 Application

The Allied Health Professional shall submit an application containing:

a. A request for authorization for specific clinical services by the AHP.
b. Adequate documentation that the AHP has achieved the minimum qualifications established by the Medical Staff rules and regulations for authorizing such clinical services.
c. An agreement on the part of both the supervising physician and the AHP to abide by the Bylaws, Rules and Regulations of the Medical Staff to the extent applicable.
d. Proof of adequate professional liability coverage for the AHP.
e. A written statement by the Supervising Physician: (i) endorsing the qualifications of the AHP for the clinical services for which authorization is requested; (ii) undertaking to supervise the AHP in the Provisions of such clinical services, if authorized; (iii) accepting responsibility for the quality of the medical care of patients who receive services from the AHP;
f. Such other information as the Medical Staff may reasonably require in support of the application.

10.4 Review of Application – The application shall be submitted to the Medical Director, and shall be processed and reviewed in the same manner as provided in Section 4.2 (b) of these Bylaws.

10.5 Membership on Medical Staff - The granting of authorization to an AHP to provide clinical services in the hospital shall not confer the rights or privileges of membership on the Medical Staff.

10.6 Termination - Any granting of authorization for clinical services by an AHP may be terminated by the Medical Director or Executive Director by written notice to the AHP and the supervising physician.

10.7 **Supervision** - If the supervising physician ceases to be a member of the Active Medical Staff unless, prior to that time, a new supervising physician assumes responsibility for the AHP by executing the agreement and written statement required by Section 9.3.

10.8 **Prohibition** - On and after the effective date of these Bylaws, no clinical services may be provided by an AHP in the hospital, unless (a) an authorization for such services has been approved in the manner provided herein, and (b) such services are provided under the direct supervision of the supervising physician.

10.9 **Temporary Scope of Practice**

a. A Temporary Scope of Practice may be granted under the following circumstances:
   i. To fulfill an important patient care, treatment, and service need;
   ii. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Executive Director and/or the Commissioner.

b. All temporary scope of practices shall be granted by the Medical Director or authorized designee on the recommendation of the Medical Staff.

c. A Temporary Scope of Practice may be granted for no more than 120 days.

d. When a Temporary Scope of Practice is granted, the Medical Staff shall verify the appropriate information regarding the individual's licensure, DEA registration (if applicable), current clinical competence and judgment, character, ethical standing, behavior, ability to safely and competently exercise the Scope of Practice requested, lack of Medicare/Medicaid/other government health care program exclusions/sanctions, and professional liability coverage and shall query the National Practitioner Data Bank, before making a decision to grant a Temporary Scope of Practice.

10.10 **Reappointment** - The Allied Health Care Professional will complete the reappointment process as defined by the Medical Staff Bylaws in Article V, Section 5.2. Recommendations from all supervising physicians must be submitted to the Medical Director for Reappointment.

ARTICLE XI

HEARINGS

11.1 **Right to Hearing** - Any person aggrieved by any proposed final action with respect to appointment or reappointment to the Medical Staff or the Allied Health Professional Staff, delineation, renewal, suspension, restriction or termination of clinical privileges, shall have the right to a de novo hearing with respect to such proposed action in the manner hereinafter provided.

11.2 **Request for Hearing** - A request for hearing under these Bylaws shall be filed with the Medical Director in writing within thirty (30) days of the date of receipt of notice of the proposed action for which a hearing is being requested. Failure to request a hearing within the thirty (30) day period shall constitute a waiver of any right to be heard, and the proposed action shall thereafter become final.

11.3 **Appeals** – All appeals shall be heard by the Commissioner of Mental Health.

11.4 **Time, Notice, and Conduct of Hearing** - If a hearing is requested on a timely basis under Section 10.2, the Medical Director shall, within fifteen (15) days of the date of receipt of such request, give written notice to the person requesting the hearing, stating: (1) the place, time and date of the hearing, which date shall be not less than thirty (30) not more than sixty (60) days after the date of such notice; and (2) a list of the witnesses (if any) expected to testify at the hearing on behalf of the VSH. Written notice of the hearing shall also be given to any VSH physician who has made a recommendation with respect to the proposed action for which a hearing has been requested. The person requesting the hearing shall have the right to be heard and present evidence, to call witnesses in his/her own behalf, and to be represented at the hearing by complete access to all files, data, and information that is confidential under applicable law.

11.5 **Decision** - The Appeals Committee shall transmit its written recommendation, which shall contain findings of fact supporting, by the preponderance of evidence, its recommendation, to the Commissioner within thirty (30) days of the conclusion of the hearing and shall simultaneously transmit a copy to the person who requested the hearing. No person shall have a right to more than one (1) hearing with respect to any proposed action under these Bylaws.

ARTICLE XII
COMMITTEES

12.1 The Medical Staff shall be represented in quality improvement initiatives through various hospital committee membership, as well as participation in focused improvement initiatives within their Medical Staff organization

12.2 Standing Committees of the Medical Staff shall include Pharmacy and Therapeutics and Executive Committee. Ad Hoc committees may be created by the Medical Director or by the Medical Staff as needed

12.3 The Medical Director will appoint members of the Medical Staff to serve on committees. All members of the Active Medical Staff are required to participate

in at least one standing committee of the hospital or Medical Staff. Appointments to these committees shall be for a period of two years and may be repeated.

12.4 Only members of the Active Staff are eligible to vote on matters that come before any committee.

12.5 The Medical Director may also ask members of the Medical Staff to participate in ad hoc committees.

12.6 The Medical Staff member serving on a standing or ad hoc committee will report on the activities of that committee to the Medical Staff.

12.7 The Medical Director is an ex officio member of all committees of the Medical Staff

12.8 Pharmacy and Therapeutics (PAT) Committee

a. Membership: The Medical Director chairs this Committee or designates another person to chair this Committee. The Director of the Pharmacy serves on this Committee as well as representatives from Nursing, Nursing Education (both appointed by the Nursing Administrator), another physician appointed by the Medical Director and a member of the Quality Management Department.

b. Frequency: The committee shall meet at least quarterly and hold such additional meetings as may be necessary to carry out its duties. Meetings of the PAT are public meetings and the schedule shall be posted in advance to allow participation by interested community members.

c. Duties:

i. Revise the Hospital Formulary on an annual basis and make recommendations for additions or deletions to the VSH Medical Staff.

ii. Investigate violations of Hospital guidelines/policies regarding use of pharmacological agents. Such violations may include, but not be limited to exceeding established maximum drug dosages, certain instances of polypharmacy, or any suspected dangerous or unethical drug practices.

iii. Review practice concerning adverse drug reactions and recommend measures to reduce or eliminate these in the future.

iv. Review medication errors and recommend measures to reduce or eliminate these in the future.

v. Monitor drug utilization practices within the Hospital.

vi. Make recommendations concerning drugs stored on the wards, in the night closet, and on the crash cart.

vii. Initiate quality improvement projects in coordination with the Quality Council.

12.9 Executive Committee

a. **Membership; Quorum; Chair**. The Executive Committee shall consist of all members of Active Medical Staff, the Medical Director, the Executive Director or designee, and the Nursing Administrator or designee. A quorum will consist of 50% of the members of the active Medical Staff and the CEO or designee and the Nursing Administrator or designee. The Medical Director or designee will serve as chairperson.

b. **Frequency.** The Executive Committee shall meet at least monthly.

c. **Duties.** The Executive Committee shall review all matters pertaining to the health and well-being of the patients, operations of the hospital and shall make suggestions and recommendations as necessary to the Commissioner tending to improve such operations and professional care. The Executive Committee shall make recommendations to the Commissioner, at least on an annual basis, including but not limited to the following matters:

i. The structure and membership of the Medical Staff.
ii. The mechanisms used to review credentials and delineate individual clinical privileges.
iii. The organization of the quality assurance activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities.
iv. Changes to and/or approval of the Medical Staff bylaws or Rules and Regulations.

ARTICLE XIII

MEETINGS OF THE MEDICAL STAFF

13.1 Meetings - The Medical Staff will meet at least monthly and more often if needed. The meeting will be chaired by the Medical Director.

Meetings will include, but not be limited to:

a. Responsibilities as a reviewing and recommending entity for privileging, appointment, and reappointment for the hospital;
b. Reports by Medical Staff members serving on hospital committees or work groups;
c. Quality improvement initiatives undertaken by the Medical Staff ;
d. Clinical issues referred to the Medical Staff organization.
e. Initiating, developing and/or approving Medical Staff Bylaws, amendments and rules.

13.2 Quorum - Presence of 2/3 of all Active Members constitutes a quorum.

13.3 Part-Time Medical Staff, Resident Trainee Medical Staff and Associate Staff members are non-voting members of the VSH Medical Staff but are encouraged to attend the Medical Staff meetings

ARTICLE XIV

RULES AND REGULATIONS

14.1 The Medical Staff shall develop and adopt a separate document constituting the rules and regulations consistent with these Bylaws as may be necessary for the proper functioning of the Medical Staff. The Medical Staff Rules may be used to define the uniform elements and standards of quality patient care, treatment and services to patients. The Rules and Regulations shall be approved by a majority vote of the Medical Staff and the Commissioner.

ARTICLE XV

AMENDMENTS

15.1 These By-laws, duly adopted by the voting members of the Medical Staff, and approved by the Commissioner, may be amended at the request of the Commissioner, the Executive Director, the Medical Director, or voting members of the Medical Staff.

15.2 The written proposed Amendment shall be circulated to members of the Medical Staff with notice of the meeting date when such an amendment will be discussed and voted on. An affirmative vote by 4/5 of the Active Medical Staff will adopt the proposed Amendment. Amendments so made shall become effective when approved by the Commissioner.

ARTICLE XVI

POLICIES AND PROCEDURES

16.1 All policies and procedures that affect physician practice in patient care must be approved by the Medical Staff.

a. Determination of whether a policy or a part of a policy affects physician practice in patient care, and therefore requires approval by the Medical Staff shall be made by the Medical Director.

b. Any changes to a policy affecting physician practice made after initial approval shall be evaluated by the Medical Director for consideration of the necessity for approval by the Medical Staff.