



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH VA 22042

IN REPLY REFER TO
BUMEDINST 6010.17C
BUMED-M51
5 Feb 2018

BUMED INSTRUCTION 6010.17C

From: Chief, Bureau of Medicine and Surgery

Subj: NAVY MEDICAL STAFF BYLAWS

- Ref: (a) DoD Manual 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) BUMEDINST 6010.30
(c) The Joint Commission Comprehensive Accreditation Manual for Hospitals
(d) The Joint Commission Comprehensive Accreditation Manual for Ambulatory Care
(e) The Joint Commission Comprehensive Accreditation Manual for Behavioral Health Care
(f) BUMEDINST 6010.31
(g) SECNAVINST 1920.6C
(h) SECNAVINST 12752.1A

Encl: (1) Navy Medical Staff Bylaws Template

1. Purpose. To serve as the formal organizational structure for privileging authorities, medical executive committees (MEC), and licensed independent practitioners granted privileges to practice in medical commands within Navy Medicine, and to assist the governing authority and organized medical staff in developing its medical staff bylaws per The Joint Commission accreditation standards. References (a) through (h) apply to this instruction. This instruction is a complete revision and should be read in its entirety.
2. Cancellation. BUMEDINST 6010.17B.
3. Scope. This instruction applies to ships and stations having medical department personnel on board.
4. Applicability. This instruction applies to all military (Active and Reserve Component) and civilian health care privileged practitioners; including those assigned, employed, contracted, or under resource sharing agreements with Department of the Navy activities. For the purposes of this document, privileged practitioners include all physicians, dentists, advanced practice registered nurses, and allied health practitioners who are eligible for independent clinical privileges as defined in references (a) and (b). References (c) through (e) are available for purchase at: <http://www.jcrinc.com/store/publications/manuals/>. All members of the medical staff are subject to credentialing and privileging requirements per reference (b) and all locally developed medical staff bylaws, rules and regulations, and policies and procedures.

5. Background. Per reference (c), each Navy medical facility or command engaged in patient care is required to develop and maintain local medical staff bylaws to provide the structure and general responsibilities of its medical staff and governing body. Enclosure (1) provides a template to use when developing facility or command specific medical staff bylaws. It outlines general obligations and rights of medical staff members. Medical staff bylaws are required and must define facility or command specific responsibilities for its providers. Additional rules and regulations can be developed to provide greater details pertaining to specific processes, to include, but are not limited to admissions, transfers, consults, autopsies, and requirements for medical records. The Navy medical staff bylaws serve as extensions of additional medical staff policies such as references (b) and (f). All medical commands must use the current applicable Joint Commission standards when developing facility or command specific medical staff bylaws, rules and regulations, or policies and procedures.

6. Responsibilities

a. Per reference (b), the Chief, Bureau of Medicine and Surgery (BUMED) fulfills the governing body responsibilities and is responsible for technical professional evaluation and execution of the Credentialing and Privileging Program.

b. Designated privileging authorities, as designated in reference (b), serve as representatives of the governing body of BUMED, and as such are ultimately responsible for the delivery of high-quality patient care at their medical command. Privileging authorities must also ensure the medical staff under their cognizance:

- (1) Establish local medical staff bylaws to comply with references (a) through (f).
- (2) Are provided access to the medical staff bylaws.
- (3) Comply with the medical staff bylaws.

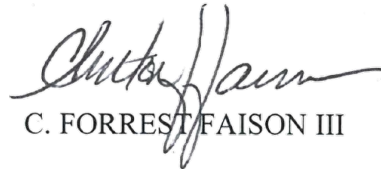
c. The MEC has primary authority for activities related to governance of the organized medical staff and performance improvement of professional services provided by licensed independent practitioners. All members of the medical staff are eligible for appointment or election to the MEC. Any medical staff member who holds clinical privileges and is actively practicing is considered eligible. MEC membership includes representation from branch clinics and clinical directorates, as applicable and feasible. The MEC is required for medical and dental commands and responsible for:

- (1) Developing local medical staff bylaws to comply with references (a) through (f).
- (2) Enforcing compliance with the medical staff bylaws.

d. Licensed independent practitioners who are eligible for independent clinical privileges as defined in references (a) and (b), are subject to credentialing and privileging requirements as set

forth in reference (c), and all locally developed medical staff bylaws, rules and regulations, and policies and procedures. Failure to abide by any of the responsibilities listed, may result in processing for separation for cause under reference (g) for military personnel or administrative or disciplinary action including termination of employment under reference (h) for civilian personnel.

7. Clinical Adverse Actions. All policies and procedures pertaining to the clinical adverse action process (i.e., abeyance, investigation, peer review panel, proposed or final adverse privileging decisions, hearing and appeal) are defined in reference (f).
8. Records Management. Records created as a result of this instruction, regardless of media and format, must be managed per SECNAV M-5210.1 of January 2012.
9. Review and Effective Date. Per OPNAVINST 5215.17A, review this instruction annually on the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, Department of Defense, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction.
10. Information Management Control. The reports required in enclosure (1), paragraphs 3d(1)(i) and 3d(5)(h) are exempt from reports control per SECNAV M-5214.1 of December 2005, part IV, paragraph 7k.



C. FORREST FAISON III

Releasability and distribution:

This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site at: <http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>.

NAVY MEDICAL STAFF BYLAWS TEMPLATE

- Ref:
- (a) The Joint Commission Comprehensive Accreditation Manual for Hospitals
 - (b) The Joint Commission Comprehensive Accreditation Manual for Ambulatory Care
 - (c) The Joint Commission Comprehensive Accreditation Manual for Behavioral Health Care
 - (d) BUMEDINST 6010.30
 - (e) BUMEDINST 6010.17C
 - (f) DoD Manual 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
 - (g) SECNAVINST 1920.6C
 - (h) SECNAVINST 12752.1A
 - (i) BUMEDINST 6010.31

1. Purpose. To serve as bylaws for licensed independent practitioners granted the privilege to practice at _____ and to assist the privileging authority and organized medical staff to maintain compliance with Department of Defense (DoD) and Bureau of Medicine and Surgery (BUMED) directives, and The Joint Commission accreditation standards. References (a) through (i) apply. References (a) through (c) are available for purchase at: <http://www.jcrinc.com/store/publications/manuals/>.

2. Applicability. These bylaws apply to all privileged practitioners as defined in references (d) and (e) to include all physicians, dentists, advanced practice registered nurses, and eligible allied health practitioners assigned to _____ and its branch health clinics. This includes all military (Active and Reserve Component) and civilian health care practitioners, including those assigned, employed, contracted, or under resource sharing agreements with Department of the Navy (DON) activities. All members of the medical staff are subject to credentialing and privileging requirements as set forth in reference (d), and all locally developed rules and regulations, and policies and procedures. Applicants for appointment to the medical staff must be familiar with the bylaws and agree in writing to abide by them.

3. Organization Structure and Roles and Responsibilities

a. Governing Body. Per reference (d), the Chief, BUMED fulfills the governing body responsibilities and is responsible for technical professional evaluation and execution of the Credentialing and Privileging Program. Privileging authorities, as designated in reference (d), serve as representatives of the governing body of BUMED, and as such are the ultimately responsible for the delivery of high-quality patient care at their medical command. Privileging authorities must also ensure the medical staff develop medical staff bylaws, are provided access to the medical staff bylaws, and comply with the bylaws. The designated privileging authority for _____ is the commanding officer.

b. Medical Executive Committee (MEC). An MEC is required for medical and dental commands. The privileging authority will appoint the MEC Chair, with medical staff input via a nominative process. [A brief description of the command's nominative process can be inserted here. If the medical staff includes non-physician or non-dentist practitioners, representation on the committee from among these practitioners is recommended. For small commands, including the operational forces, the medical staff as a whole may serve as and fulfill the functions of the MEC. This enclosure recognizes there are alternative methods of organizing management of operational medical departments to meet mission requirements.]

c. The MEC Chair should be a senior member of the medical staff.

d. All members of the medical staff are eligible for appointment or election to the MEC. A medical staff member actively practicing cannot be considered ineligible based solely on the professional specialty, discipline, or officer corps. MEC membership includes representation from branch clinics and clinical directorates, as applicable and feasible. [A description of the command's specific information about the MEC including its function, size, composition, scope of responsibilities, and delegated authority can be inserted here.]

(1) MEC Functions

(a) Develops medical staff bylaws, rules and regulations, and policies and procedures per BUMED directives and Joint Commission accreditation standards.

(b) Provides oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged at their command.

(c) Provides oversight of the credentialing and privileging processes.

(d) Reviews applications and makes recommendations directly to the privileging authority for medical staff membership with clinical privileges.

(e) Considers input from all sources, including peer review, concerning the appropriateness of clinical privileges requested by health care practitioners.

(f) Recommends to the privileging authority specialty and facility-specific criteria for staff appointments with clinical privileges.

(g) Provides recommendations and justifications to the privileging authority regarding credentialing and privileging actions.

(h) Documents MEC actions by preparing and maintaining meeting minutes that include, but are not limited to:

1. Convening of meetings.
2. Meeting attendance.
3. Recommendations and justification regarding credentialing and privileging actions.
4. Rationale to support recommendations regarding deviations from this instruction.

(i) Oversees the completion and submission of the Performance Appraisal Report (PAR) for all health care practitioners practicing within the command.

(j) Responsible for evaluating the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluations (OPPE) of all practitioners, and determining actions for performance improvement actions to ensure patient safety.

(k) Seeks amplification and clarification, and makes recommendations to the privileging authority regarding practitioner professional performance when there is reason to believe the practitioner is not performing within his or her delineated clinical privileges, not abiding by policies, procedures, and bylaws per references (d) and (e), or not practicing within acceptable standards of care.

(l) Ensures professional staff monitoring is performed per references (d) through (f).

(m) Assists in developing, reviewing, and recommending actions on local policies and procedures for providing health care services, as needed.

(n) Works collaboratively with the Chief Medical Officer to develop initiatives and ensure compliance with applicable policies.

(2) Credentials Review Committee (CRC). [If applicable, a description of the command's specific information about the CRC including its function, size, composition, scope of responsibilities and delegated authority can be inserted here. For example, in facilities where workload dictates, the privileging authority may delegate credentialing and privileging functions to the CRC, to serve as a subcommittee of the MEC. Such delegations may include, but are not limited to, FPPE and OPPE activities. The MEC retains responsibility for oversight and endorsement of the activities of the CRC.] The CRC membership must be as follows:

(a) The CRC Chair is selected from among the membership of the MEC and appointed by the privileging authority.

(b) CRC members are nominated by the MEC and appointed by the CRC Chair.

(c) Only privileged licensed independent practitioners permanently assigned to the command may be appointed to the CRC.

(3) Department Heads

(a) Department heads with clinical oversight responsibilities must have active clinical privileges, and either current board certification by the appropriate specialty board, or comparable experience and credentials to practitioners assigned to the department.

(b) Brief all practitioners applying for a medical staff appointment with clinical privileges within their department on the local Credentialing and Privileging Program. Ensure all departmental staff receives orientation and allowed opportunities for continuing education (CE).

(c) Continuously monitor and document the professional clinical performance, conduct, and health status of department staff members to ensure they provide health care services consistent with clinical privileges and responsibilities. Monitor quality management and medical staff activities for practitioners assigned to their department and complete PARs for those practitioners. Maintain OPPE data for all licensed independent practitioners within the department. Ensure FPPEs are implemented and completed appropriately for new providers upon checking into the command and in circumstances outlined in this policy. Ensure the OPPEs are conducted regularly and aggregated data is documented at a minimum of once every 8 months for all providers.

(d) Ensure non-privileged practitioners, clinical support staff, and other personnel providing health care services in the department receive appropriate clinical supervision.

(e) Maintain approved staff appointments with delineated clinical privileges on practitioners assigned to their departments in either electronic or paper form. Ensure practitioners' privileging information is readily available to all internal personnel as informational purposes. For non-trainee, non-privileged providers practicing under supervision (i.e., clinical psychologists and social workers who have not fulfilled clinical hours required for degree), the plan of supervision must be maintained in the department as well as in the provider's permanent credentials record.

(f) Recommend departmental, specialty, and facility-specific criteria for staff appointment and reappointment with clinical privileges.

(g) Make recommendations for staff appointment with delineated clinical privileges based on the applicant's professional qualifications, health status (ability to perform), current competence, verified licensure, education and training, and National Practitioner Data Bank query.

(h) Use practitioner-specific results of quality management and risk management monitoring activities when making recommendations for staff appointments with clinical privileges.

(4) Clinical Directors

(a) Continuously monitor the professional clinical performance, conduct, and health status of clinical department heads to ensure they provide health care services consistent with clinical privileges and responsibilities. Monitor quality management and medical staff activities for clinical department heads assigned to the directorate, and complete a PAR for those practitioners. Maintain OPPE data for all department heads under your directorate. Coordinate with the medical services professional to ensure FPPEs for department heads are implemented and completed appropriately.

(b) Monitor the credentialing and privileging process within their directorates.

(5) Organized Medical Staff. All military (Active and Reserve Component) and civilian physicians, dentists, allied health practitioners, and advanced practice nurses who hold independent clinical privileges are eligible for appointment to the organized medical staff. References (a) through (d) provide additional information. All members of the medical staff are responsible for the following:

(a) Initiate an application for membership to the medical staff and request the broadest scope of clinical privileges commensurate with their professional qualifications, level of current competence, and the facility's ability to support the privileges requested. Those who fail to maintain qualifications or do not request such privileges are subject to processing for separation for cause under reference (g) for military personnel for administrative or disciplinary action including termination of employment under reference (h) for civilian personnel.

(b) Comply with applicable professional staff policies, procedures, and bylaws per these medical staff bylaws.

(c) Ensure the accuracy and currency of all credentials and privileging information reflected in their credentials record (i.e., licensure status, board certification, and privilege status at other facilities at all times).

(d) Immediately inform the privileging authority via the medical services professional of any change in status of any professional qualification, including health status, which could impair their ability to provide safe, competent, and authorized health care services.

(e) Immediately disclose (within 7 calendar days) to the privileging authority via the medical services professional any change in his or her professional qualification, to include investigations or actions by any State licensing board or certification agency. Failure to timely disclose such information may be considered professional misconduct and a basis to initiate a clinical adverse action.

(f) To immediately disclose (within 7 calendar days) to the privileging authority via the medical services professional any change in his or her health status that may prevent or impact the practitioner's ability to provide safe health care. Written medical clearance may be required from the treating physician in order to remain engaged in clinical patient care.

(g) For practitioners with infectious diseases (hepatitis B virus, hepatitis C virus, or the human immunodeficiency virus, etc.), refer to enclosure (3) of reference (d), for specific practitioner requirements to report their health status to each facility or command where they will be engaged in patient care activities.

(h) Perform health care services within the scope of either the privileges granted by the privileging authority or the written plan of supervision for those practitioners required to practice under supervision.

(i) Participate in professional CE programs. [Command may specify minimum number of CE requirements in conjunction with respective State licensing requirements here and they may be broken down by specialty.]

(j) Actively support and participate in facility quality management activities and meetings as required.

(k) Provide the appropriate documentation to clarify or remove any credentialing discrepancies or missing information of any type. All credentialing discrepancies or missing information requires satisfactory resolution. In the absence of required credentialing information or clarifying documentation, the privileging application is considered incomplete, and therefore cannot be processed.

(l) Provide accurate and current information and evidence of professional qualifications.

4. Qualifications for Appointment to the Medical Staff. All licensed independent practitioners listed in enclosure (4) of reference (d) are eligible for appointment to the medical staff. Licensed independent practitioners must have clinical privileges in order to be appointed to the medical staff. Medical staff appointments expire upon the practitioner's detachment from the command due to permanent change of station, end of employment or contractual agreement, medical command closure, retirement, or release from active duty. Procedures related to clinical adverse actions affecting privileges based on clinical incompetence, impairment, or professional misconduct are described in references (f) and (i).

5. Credentialing and Privileging Process. All policies pertaining to the credentialing and privileging process are defined in reference (d). [A brief description of any of the command's specific credentialing and privileging process can be inserted here.]

6. Privileging Categories. All policies pertaining to the credentialing and privileging process are defined in reference (d).

7. Privileging Criteria

a. Master Privilege List. Each of the specialty-specific privileges in the master privilege listing, which can be found in the Centralized Credentials Quality Assurance System, contains two categories of privileges, core and non-core.

b. Core privileges constitute the expected baseline scope of care for a fully trained and currently competent practitioner of a specific health care specialty. These privileges must be applied for and granted as a single entity. Since core privileges constitute a baseline scope of care, not all core privileges are required or expected to be exercised at all times in every medical command. Privileges per reference (d), must be relevant to a given medical command. Privileging authorities must inform practitioners in a timely manner of any command-specific policies or procedure restrictions that preclude providing health care services within the core privileges. Command limitations will be determined by the department, endorsed by the MEC, approved by the privileging authority, and reviewed annually. The core privileges are not to be modified locally. Changes to the core privileges can be made only by the applicable specialty leader.

c. Non-core privileges are itemized, command-specific privileges that are relevant to the specific health care specialty. Additionally non-core privileges fall outside the general core scope of care due to the level of risk and specialty training necessary; the requirement for unique medical command support staff or equipment; or the level of technical sophistication required to support the privilege. Non-core privileges may be requested and granted on an item-by-item basis. Criteria for granting non-core privileges must be developed by the department, endorsed by the MEC, approved by the privileging authority, and reviewed annually. Non-core privileges may be modified locally to reflect the scope of care the medical command can support and expects to provide.

d. Departmental specific criteria for each non-core privilege support at the command must be reviewed and updated annually.

e. In instances where the expected scope of care is very limited or significantly less than the full core privileges, the medical command may grant itemized privileges to be exercised exclusively at its medical command.

f. Practitioners, to the degree permitted by their license, training, the law, and DoD or DON rules and regulations, are authorized and expected to render such care as is necessary to save or protect the welfare of individuals in an emergency situation. Accordingly, emergency privileges are automatically awarded to practitioners by virtue of their staff appointment, negating the need for individual or specific delineation of emergency privileges. The provision of this paragraph

does not negate the requirement for practitioners assigned to provide emergency care services to hold appropriate clinical privileges or be appropriately supervised if practicing under supervision.

8. Histories and Physical Examinations

a. A medical history and physical examination must be completed and documented by a privileged licensed independent practitioner per their clinical privileges.

b. All patients admitted for inpatient care must have a history taken and a comprehensive physical examination performed no more than 30 days before or within 24 hours after admission by a member of the medical staff with clinical privileges. This examination must be completed and documented in the patient's medical record within 24 hours after admission.

c. The following practitioners are authorized to perform a medical history and physical examination:

(1) Physicians who hold clinical privileges may perform the history and physician examination.

(2) Oral and maxillofacial surgeons who hold clinical privileges, and admit patients without significant comorbidities, may perform the history and physical examination on those patients.

(3) Dentists who hold clinical privileges are responsible for the part of their patient's history and physical examination as it relates to dentistry.

(4) Podiatrists who hold clinical privileges are responsible for the part of their patient's history and physical examination as it relates to podiatry.

(5) Other practitioners, who are permitted to provide patient care independently, may perform the history and physical examination, if they hold core privileges in their clinical specialty.

d. For patients receiving ambulatory care services, a complete history and physical exam must be performed.

e. Periodic Health Assessments, used to ensure individual medical readiness of Navy and Marine Corps Active and Reserve Component Service members, may be approved by a physician, advanced nurse practitioner, or physician assistant who holds clinical privileges.

9. Medical Record and Documentation Requirements

a. [Command specific requirements for medical records and documentation may be provided in local rules and regulations or additional policies, or can be added to this section of the medical staff bylaws.]

b. Medical records must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the results. A good medical record should permit another medical staff member to assume care of the patient at any point in their course of treatment. Entries must be dated, timed, legible, and signed. Failure to complete medical records per local medical staff rules and regulations may result in an administrative action to include a possible clinical adverse action.

10. Voting Members of the Medical Staff

a. [Describe the command's rules for identifying members who are eligible to vote.]
[Describe the command's requirements for meeting quorum.]

b. All practitioners who are appointed to the command's MEC are eligible to vote on matters related to the command's organized medical staff and quality of care. Although consensus is desired for all committee actions, a simple majority vote is sufficient to forward recommendations. Minority opinions should be included in the minutes.

11. Election or Appointment to the Medical Staff

a. All members of the medical staff are eligible for nomination and appointment to officer positions. The MEC Chair and Vice Chair positions will be appointed by the privileging authority following a nominative process facilitated by the command's organized medical staff (all licensed independent practitioners appointed to the medical staff are eligible to vote). All other officer positions will be selected by the MEC, and appointed by the MEC Chair.

b. MEC Chair and Vice Chair positions should be no less than 1 year in duration, but would preferably be 2 years to ensure continuous stable leadership. When staffing and billeting permits, the MEC Vice Chair should be appointed as Chair upon the current Chair's tenure completion. A new Vice Chair will be elected and appointed no less than 6 months prior to the current MEC Chair's tenure completion.

c. Any officer who fails to satisfactorily comply with obligations outlined in these medical staff bylaws, is subject to removal from their positions by the privileging authority. Such removal should be reflected on the provider's PAR and Fitness Report.

12. MEC Officer Positions. [Describe command specific MEC officer positions. The following is provided as an example.]

a. Membership to the MEC includes the following positions:

(1) Chair, MEC/President of the Medical Staff

(2) Vice Chair MEC/Vice President of the Medical Staff

- (3) Chair – Credentials Review Committee
- (4) A practitioner for medical specialties
- (5) A practitioner for surgical specialties
- (6) A practitioner for aviation medicine (as needed)
- (7) A practitioner representative from branch health clinic
- (8) An allied health practitioner
- (9) A practitioner for dental specialties
- (10) The performance improvement physician advisor
- (11) An advanced nurse practitioner

b. Non-Voting Membership

- (1) Executive officer
- (2) Medical services professional
- (3) Risk manager
- (4) Director Nursing Service/Nursing Executive Committee Chair
- (5) Graduate medical education trainee (when available)

13. Adoption and Amending the Medical Staff Rules, Regulations, and Policies. [Describe the commands process for adopting and amending the medical staff bylaws, local rules and regulations and other local policies.]

a. Medical staff must have the responsibility to formulate, review at least biennially, and recommend to the privileging authority any changes to the medical staff bylaws, rules, regulations, policies and procedures, and amendments as needed, which must be effective when approved by the privileging authority.

b. Review and document constructive comments by the members of the staff, and obtain a two-thirds vote of the voting staff at a regular or special meeting of the staff, provided a quorum is present. Notice of meeting must contain express reference to the review of these proposed bylaws.

c. An amendment must be effective when approved by the privileging authority.

14. Clinical Adverse Actions. All policies and procedures pertaining to the clinical adverse action process (i.e., abeyance, investigation, peer review panel, proposed/final adverse privileging decisions, hearing and appeal) are defined in references (f) and (i).

MEC Chairperson
Approve or Disapprove
Date

Privileging Authority
Approve or Disapprove
Date